Snake River Juvenile Detention Center
650 Addison Avenue West, Suite 3200
Twin Falls, ID 83301

CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT AND MEDICAL INFORMATION

I, the undersigned parent/guardian hereby consent to my child/ward receiving medical, dental, optometry, surgical and/or psychological diagnosis and treatment for my child's health and well being. This includes laboratory tests recommended or ordered by the examining medical professional for:

_____

Any youth in our custody who requires medical care will receive such care , if necessary, including but not limited to emergency care, surgery and anesthesia.

I, the undersigned parent/guardian of the above named juvenile, authorize Snake River Juvenile Detention Center personnel to receive/disclose medical information to and from all medical services agencies and medical personnel providing medical services to the above named juvenile.

In addition, it is the responsibility of parents or guardians to pay for any medical or dental care required outside this agency, including prescription.

I, the undersigned parent/guardian, have read this policy and understand it. I fully consent to my child receiving the medical care required for his or her health and well being. I understand that an attempt will be made to contact me immediately to obtain medical consent. In the event that a competent medical authority finds a delay in getting my consent for a specific emergency medical procedure and this delay would result in harm to my child, I agree that this document constitutes my consent. Further, I agree that this document will constitute as an official consent for such medical care or surgery by a regularly licensed medical care professional any time when the above named child is in the custody of the Snake River Juvenile Detention Center up to the age of eighteen (18), unless such consent is revoked in writing and/or the child's custody is transferred to another individual or entity.

IN CASE OF EMERGENCY:
Home Number:_____ Cell Phone:_____
Work Number: _____ Email: _____

Family Physician: _____

Insurance Information: _____

Signed:_____ Relationship: _____ Date:_____

Staff: _____ Date: _____