DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

MEDICAL SERVICES CONSENT

Use of form: Use of this form is voluntary, but completion will aid caretakers in ensuring that appropriate and timely health care is provided. The form is to be completed by the parent or guardian of a child placed in foster care or treatment foster care. Personally identifiable information on this form will be used for identification purposes and to assure appropriate medical care for the child. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: If additional space is needed, attach a separate sheet or use reverse side of this form.

Name – Parent or Guardian (Last, First, MI)	
Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

A. Routine Medical Services Consent and Exclusions

For purposes of routine medical services for the above named child, I hereby give my consent for the child placing agency or its designee to approve the provision of routine medical services*, including medical and dental examinations and nonemergency prescribed treatments (e.g., tooth repair, immunizations, medications, reproductive health needs assessment), with the following exceptions:

* All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

B. Routine Emergency Medical Services Consent and Exclusions

In case of a medical emergency involving the above named child, I understand that the following procedures will be used. I hereby give my consent for the child placing agency or its designee to arrange for emergency medical services using the following procedures:

1. A reasonable effort will be made to contact me and secure my consent for needed medical services, including surgical procedures.
2. If I cannot be located within a reasonable time, the placing agency has the authority to consent to emergency surgery.
3. The juvenile court has the authority to consent to other medical services.
4. All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

I have no objections to the placing agency exercising its authority, with the following exceptions:

C. Parent / Guardian Information

Address – Home (Street, City, State, Zip Code)	Telephone Number – Home
Address – Work (Street, City, State, Zip Code)	Telephone Number – Work
Address – Other (Specify)	Telephone Number – Other (Specify)
Address – Other (Specify)	Telephone Number – Other (Specify)
SIGNATURE – Parent / Guardian	Date Signed
SIGNATURE – Child (age 14 and over only)	Date Signed