Perry Multi-County Juvenile Facility

CONSENT FOR MEDICAL TREATMENT

☐ My child is a minor, and is unable to consent because of their age.

Parent/Guardian

1. I, _____, make oath and say that I am the lawful parent/guardian of (child's name) _____ and there are no court orders in effect that would prohibit me from conferring the power to consent upon another person.
2. I hereby authorize and appoint **Perry Multi-County Juvenile Facility of 1625 Commerce Drive in New Lexington, Ohio** as my Agent. Unless otherwise provided in this authorization, my Agent may consent to emergency and routine treatment for my child including dental treatment, anesthesia and blood transfusion.
3. My Agent may have access to any and all records, including but not limited to, insurance records regarding any medical services or treatment provided.
4. The purpose of this instrument is to give Perry Multi-County Juvenile Facility the power and authority to consent to medical treatment for my child. This power and authority will be effective as of the date of facility entry.
5. I give this consent freely and knowingly in order to provide for the child and not as a result of coercion, duress or payments by any person or agency.

Parent/Guardian Signature: _____ Date: _____

☐ I am eighteen years or older, or a legally emancipated minor. I am able to give medical consent.

I, _____, am presenting myself for treatment to the authorized medical provider and voluntarily consent to the rendering of such care, including emergency, diagnostic and surgical procedures and medical treatment by authorized agents and employees of the authorized medical provider or their designees, as may in their professional judgment be deemed necessary or beneficial.

I am aware that the practice of medicine is not an exact science and acknowledges that no guarantees have been made to me as to the results of treatment and/or examination.

I HEREBY, further authorize the authorized medical provider to release to any person or corporation, including but not limited to, my insurance company, any physician, hospital, nursing home, nursing service, social agency, welfare agency, or governmental agency, who in the best judgment of the authorized medical provider has a legitimate interest to the information requested contained in my medical records.

This form has been fully explained to me, and I certify and acknowledge that I understand its contents. I may revoke this form at any time in writing.

_____ _____

Signature of Patient/Resident Date

_____ _____

Signature of Parent/Guardian (with relationship to patient) Date