Warren County Juvenile Detention Center Medical Authorization

*** * * * * (Part I or II MUST be completed) * * * * ***

Part I – To Grant Consent

I _____, parent of _____ hereby give permission for the medical staff of Warren County Juvenile Detention Center (WCJDC) to give my child the medications listed below as appropriate according to the physician-approved protocols. I contend that to the best of my knowledge my child is **NOT** allergic to any of the approved medications.

Please list any known allergies: _____

Common Brand Name		Check Y or N	Common Brand Name		Check Y or N
Tylenol – Acetaminophen	(fever, pain)	☐ Y ☐ N	Hydrocortisone cream	(mild burns)	☐ Y ☐ N
Ibuprofen (Advil, Motrin)	(fever, pain)	☐ Y ☐ N	Tinactin spray	(athlete's feet)	☐ Y ☐ N
Benadryl	(allergies-allergic reactions)	☐ Y ☐ N	Triple antibiotic cream	(scrapes/cuts)	☐ Y ☐ N
Milk of Magnesia	(constipation)	☐ Y ☐ N	Aller-CHLOR	(allergies-allergic reactions)	☐ Y ☐ N
Cough syrup		☐ Y ☐ N			

Doctor's Name: _____ Doctor's Phone Number: (_____) _____

Medicine	Dose	Time(s)	Reason(s) for Medication

Authorization for Medical and Dental Care and release or exchange of Personal Information

I hereby grant permission to WCJDC and/or any physician, dentist, hospital or qualified medical personnel designated by said Center to conduct a routine physical, provide any medical or dental care, and to perform any psychological or diagnostic tests (including pregnancy tests, tuberculin skin tests, and venereal disease testing) as deemed necessary and in the best interests of my child.

All test results remain confidential. I also consent that this information may be obtained by and/or released to the staff of other allied agencies with similar policies of confidentiality. Such information is used in the best interests and for the well-being of the above-mentioned child at the discretion of the WCJDC staff in agreement with Warren County Juvenile Court.

Financial Responsibility

Insurance Company: _____ Employer: _____

Address: _____ Telephone: _____

_____ _____

Signature of Parent or Guardian **Date**

Part II – Refusal to Consent (Do not fill out if you filled out Part I)

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I request the WCJDC staff to take no action or to:

_____

_____ _____

Signature of Parent or Guardian **Date**

CC: Inmate File (Original) Medical C:\Users\howats\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\3J9P3E6Y\Medical Authorization.docx

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