ALLEN COUNTY JUVENILE CENTER CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD & AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I (We) ______________________________ and ______________________________
Name (Parent/Guardian) Name (Parent/Guardian)

of ______________________________, ________________, ____________, __________
(City) (County) (State) (Zip)

state that I am (we are) the parent(s) or legal guardian(s) of ______________________________
(Juvenile's Name)

a minor child, age __________ born ________________________ who resides with me (us) at

______________________________, ________________, ____________, __________
(Address) (City) (State) (Zip)

I (We) authorize Allen County Juvenile Center, 2929 Wells Street, Fort Wayne, Indiana, 46808, County of Allen, State of Indiana to consent to any necessary examination, medical diagnosis, release of medical information, treatment or hospital care to be rendered to the above named minor child under the general or special supervision and on the advice or any physician or surgeon licensed to practice medicine in the state of Indiana. This consent to disclose information may be revoked by me in writing at any time, except to the extent the action already has been taken. This consent (unless expressly revoked earlier) expires in one year or when the child is released from the jurisdiction of the Court, whichever first occurs.

Dated this _______ day of ______________________, 20______
(Day) (Month)

______________________________ ______________________________
(Signature of Parent/Guardian) (Signature of Parent/Guardian)

______________________________ ______________________________
(Juvenile's Signature) (Witness)

Medical Insurance Carrier:

____

Identification Number: ____________________

Member's Name: ____________________

Account Number: ____________________

Medicaid Number: ____________________

Family Doctor(s): ____________________

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Medical Information:

____

____

Allergies: ____________________

Chronic Existing Diseases (IE: diabetes, epilepsy):

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Current Medication(s): ____________________

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