

## Consent for Treatment and Release of Medical Information

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Youth Name	Legal Guardian / Parent	Relationship to Youth
Address	City	State Zip
Phone	Cell Phone	

**Medication**

I, \_\_\_\_\_, the legal guardian of \_\_\_\_\_, a minor child, give permission for Baldwin Youth Services to administer the following prescription medication(s), as well as any non-prescription medications that may be needed for said child. Please list all medications child is currently taking:

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I hereby grant permission to any Baldwin Youth Service agent(s) to consent to any medical treatment, to administer medication and, if needed, to arrange transport for the named child to any physician, hospital or dentist to provide the necessary medical treatment as in his/her opinion is necessary for the named child above. I further authorize any physician, hospital, dentist or clinic to furnish BYS any verbal or written information pertaining to the child named above. I authorize that a photocopy of this release may be considered as valid as the original. I also accept full financial responsibility for service rendered to the named child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Insurance Information

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_ Policy # \_\_\_\_\_

Medical condition/s: \_\_\_\_\_  
Allergies: \_\_\_\_\_

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### Staff / Witness

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

### For Emergency Authorization Only

To: Authorized Physician, Dentist, Hospital or Clinic

The above named child has been placed in Baldwin Youth Services physical custody and is referred to you for medical treatment. It is requested that the bill be mailed to the legal guardian, insurance company or Medicaid as listed above.

Authorized BYS agent \_\_\_\_\_ Date \_\_\_\_\_ Title \_\_\_\_\_

**Baldwin Youth Services  
Group Home Transportation & Communication List**

**Transportation**

*List below the person or persons that are allowed to bring your child back or pick up your child on the weekends. The individuals listed below must be an adult no exceptions. They also cannot be romantically involved with your child. Each individual person must have a copy of driver's license on file.*

Name	Relationship to child	Yes <input type="checkbox"/> No <input type="checkbox"/> D.L. on File
Name	Relationship to child	Yes <input type="checkbox"/> No <input type="checkbox"/> D.L. on File
Name	Relationship to child	Yes <input type="checkbox"/> No <input type="checkbox"/> D.L. on File
Name	Relationship to child	Yes <input type="checkbox"/> No <input type="checkbox"/> D.L. on File

**Communication:**

*This is a list of individuals other than the legal guardian that we can contact or speak to concerning your child.  
Ex. Step parent, grandparent*

Name	Relationship to child	Phone
Name	Relationship to child	Phone

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



P.O. Box 1135  
Robertsdale, Alabama 36567

BH: 251-947-5266  
GH: 251-945-3006

**\*Appointment must be made & reported to BYS by Friday. Due Date:**

### Child's Medical Record

Medical Facility: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Temp: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

General Appearance: \_\_\_\_\_ Abnormalities: \_\_\_\_\_ Skin: \_\_\_\_\_

Allergies: \_\_\_\_\_

#### TEST

EXAM	DATE	RESULT
Urinalysis		
Hemoglobin		
TB Skin Test		

#### PREVIOUS ILLNESS (LIST AGE)

Measles		Tonsillitis		Diphtheria	
Mumps		Common Cold		Pneumonia	
Whooping Cough		Poliomyelitis		Other	

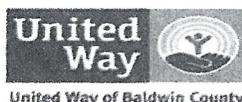
#### Check One and Sign

I examined this child on the above date and found child to be free of contagious and infectious diseases.

I examined this child on the above date and found the child was NOT free of contagious and infectious disease.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Please provide a copy of the child's immunization record to our facility. \***



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### Child's Dental Record

Dental Facility: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Dental Facility Address: \_\_\_\_\_

Dental Facility Phone: \_\_\_\_\_ Dentist: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnostic/Preventive Service	YES	NO
Examination		
X-rays		
Cleaning		
Fluoride		
Fillings		
Crowns		
Extractions		
Sealants		
Emergency Care		

I examined child and found child to be free of any current dental needs, and their next preventive exam is due \_\_\_\_/\_\_\_\_/\_\_\_\_.

I examined child and found need for further treatment, as recommended below.

Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dentist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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