Consent for Treatment and Release of Medical Information

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:

_____

_____

_____

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: _____

Insurance Information

Insurance Company _____ Phone _____ Policy # _____

Medical condition/s: _____

Allergies: _____

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 ____ No____ D.L. on File
Name	Relationship to child	Yes ____ No____ D.L. on File
Name	Relationship to child	Yes ____ No____ D.L. on File
Name	Relationship to child	Yes ____ No____ 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. ***

United Way of Baldwin County

A Member Agency of United Way

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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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08Nov22