

**RELEASE FOR MEDICAL/DENTAL/SURGICAL TREATMENT**

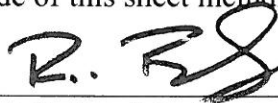
It is the policy of Ada County Juvenile Court Services (ACJCS) that all youth who are admitted to Detention receive a health appraisal and any necessary laboratory test while in custody.

Further, it is the policy of ACJCS that all youth who are admitted to or in placement with ACJCS programs and require emergency medical care will receive such care.

Should emergency medical care be required, the youth will be transported to either St. Alphonsus Hospital or to St. Luke's Hospital. The emergency staff at the hospital will determine the necessary treatment.

*It is the responsibility of the parent(s) or guardian(s) to pay for any medical/dental/surgical/psychiatric treatment, anesthesia, or prescriptions reasonably required while the juvenile is in the care, custody, or control of ACJCS. It is also the responsibility of the parents/guardians to provide all information requested on the reverse side of this sheet including insurance information.*

THIS IS SO ORDERED:



\_\_\_\_\_  
Ransom J. Bailey, Magistrate Judge



\_\_\_\_\_  
Cathleen MacGregor-Irby, Magistrate Judge

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**PARENT/GUARDIAN STATEMENT**

I have read the policy of Ada County Juvenile Court Services stated above and understand it. By signing this release, I am authorizing any medical care reasonably required for my child's health and well-being while in the care, custody and control of ACJCS.

In the event that competent medical personnel find a delay in getting my consent for a specific emergency medical procedure, and that this delay would result in harm to my child, I agree that this document constitutes my consent.

Further, I agree that this consent is valid for one year from the date it is signed.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of Juvenile

**\*\*\*RETURN TO FRONT DESK\*\*\*  
WHEN COMPLETED**

**(Complete all - even if there is no insurance. This is billing information in case of a medical emergency.)**

**Juvenile's Information:**

Name: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Current Medications \_\_\_\_\_

Emergency Contact \_\_\_\_\_

**Insurance Information:**

Insurance Carrier \_\_\_\_\_

Policy/Member Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Insured/Subscriber or Responsible Party's Information:**

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_

Employer's Name and Address  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Name of Parent (printed) \_\_\_\_\_

Relationship to Juvenile \_\_\_\_\_

Custodial Parent (if different from above) \_\_\_\_\_

Address \_\_\_\_\_

Phone number(s) \_\_\_\_\_

**\*\*\*RETURN TO FRONT DESK WHEN COMPLETED\*\*\***