Consent for Emergency or Routine Medical/Dental Treatment
Lucas County Children Services, 705 Adams Street, Toledo, OH 43604

Child's Name _____ **DOB** _____

Routine Care
The undersigned legal custodian hereby gives consent for the above named child to receive treatment, including routine medication and immunizations from the physician/clinic/hospital/dentist chosen by the agency and/or substitute caregiver. In addition, this form authorizes the administration of medication necessary for conscious sedation.

This form does not authorize any procedure that would require informed consent, such as elective surgery or invasive testing procedures. This form does not authorize the initiation of psychotropic medication outside of an emergency situation.

Emergency Care
In the event of an emergency, the medical facility and its providers are hereby authorized to initiate and perform any required emergency treatment and procedures deemed necessary for the health and the safety of the child. This shall include the administration of anesthetics determined to be necessary by competent medical/dental opinion. It is hereby understood that the medical facility and the providers participating in this child's treatment are also taking all appropriate steps to contact Lucas County Children Services during this emergency event.

Substitute Caregiver Name: _____
(Foster or Relative or other LCCS Designee)

The substitute caregiver is hereby authorized to release any information concerning the child, which is necessary to provide routine or emergency medical care for the child to any individual or facility providing such treatment.

The substitute caregiver may receive medical information, follow up instructions, discharge orders, and prescriptions from providers as an agency representative.

The child may be released to the designated substitute caregiver.

Lucas County Children Services
Health Services Department

Monday - Friday 8:30 am - 4:30 pm
419-213-3205 or 419-213-3481

Monday - Friday 4:30 pm - 11:00 pm
419-213-3200

Health Services Fax: 419-327-3358

Monday - Friday after 11:00 pm/Weekends and Holidays Call LCCS Security 419-213-3200

Legal Custodian of the Child:

_____ _____
Executive Director – Lucas County Children Services Date

This Consent for treatment expires 180 days from the effective date.

Note: **Custody status is subject to change. Contact 419-213-3200 to verify current custody status.**

LCCS 7008 - Doctor/Dentist/Hospital file
LCCS 7009 - Please return **completed** LCCS Health Visit Report to Lucas County Children Services

Lucas County Children Services
Health Visit Report

Child's Name _____ **Date of Birth** _____

Type of Visit - This section must be completed **Date of Visit** _____

- ☐ Comprehensive Physical *(which includes healthcheck requirements and vision and hearing screenings appropriate for age e.g., tracking, tuning fork, Snellen)*
- ☐ Dental Appointment
- ☐ Follow-Up ☐Treatment Ongoing ☐Treatment Completed
- ☐ Sick Visit
- ☐ Specialist Visit *(vision, hearing evaluation)*
- ☐ Emergency Room Treatment

Height:		Weight:
Temp:	BP:	P:
Head Circumference:		
Hgb:		
Lead:		
Sickle Cell:		

Diagnosis _____

_____

_____

Treatment *(Describe medical/dental treatment and prescriptions ordered)* _____

_____

_____

Immunization(s) Given TODAY *(please check)*

☐ DPT/DT/Td # 1	☐ HBV # 1	☐ HIB # 1	☐ IPV #1	☐ MMR #1	☐ PCV # 1
☐ DPT/DT/Td # 2	☐ HBV # 2	☐ HIB # 2	☐ IPV #2	☐ MMR #2	☐ PCV # 2
☐ DPT/DT/Td # 3	☐ HBV # 3	☐ HIB # 3	☐ IPV #3		☐ PCV # 3
☐ DPT/DT/Td # 4		☐ HIB # 4	☐ IPV #4	☐ Prevnar	☐ PCV # 4
☐ DPT/DT/Td # 5					
		☐ HPV		☐ TB Test	☐ Varicella

Other: _____

_____

Tests *(Completed today and results, if available (e.g., dental x-ray and/or results, urinalysis, throat culture)*

_____

_____

Other Areas of Concern ☐ Social ☐ Educational ☐ Developmental ☐ Emotional
☐ Other: _____

Child was Referred to: Name _____ Specialty _____

Please ask the ☐ LCCS Caseworker ☐ LCCS Health Services RN to contact the physician's office below regarding: _____

_____

_____

Medical Provider's Signature *(Doctor/Dentist/Specialist)* Date

_____

_____

_____

Print or Stamp Name & Address of Physician ***(This must be completed)***

LCCS Health Services: 419-213-3205/419-213-3481 Fax: 419-327-3358

(To return this form to LCCS, please fold at dotted lines on reverse side so address shows.)

LCCS 7009
Rev. 3/2018