DEPARTMENT OF CHILDREN AND FAMILIES
Division of Milwaukee Child Protective Services

Authorization to Consent to Medical Treatment

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Name – Child	Birthdate

Name – Responsible Party	Specify Relationship to Child ☐ Parent ☐ Legal Guardian or Legal Guardian's Designee**

To Responsible Party: Carefully read all statements and check "Yes" or "No" to indicate your consent for the following

Yes	No		
☐	☐	1.	**Routine Medical Care:** I hereby authorize the Division of Milwaukee Child Protective Services (DMCPS) or the foster parents / relative caregiver to arrange and consent for routine medical, dental, and mental health care for the child through the designated foster care medical home provider network. Routine medical care includes immunizations, an assessment of the child's medical, nutritional (growth), dental, developmental, and emotional / behavioral status including mental health screening. All such services will be under the direction of a licensed physician, dental care provider, or other licensed health care or mental health care professional as appropriate.
☐	☐	2.	**Emergency Medical Services:** I hereby authorize the DMCPS or the foster parents / relative caretaker to arrange for and consent to emergency medical services using the following procedure: a. A reasonable effort will be made to contact me and secure my consent for needed emergency services, including surgical procedures. b. If I cannot be located within a reasonable time, the DMCPS or the foster parent / relative caregiver has my authorization to consent to emergency surgery. c. All medical services will be provided under the direction of a physician or other licensed health care professional as appropriate.
☐	☐	3.	**Medication:** I hereby authorize the foster parent / relative caretaker to administer previously prescribed medication to the above-named child.
☐	☐	4.	I have health insurance that covers this child. I affirm that I will maintain this insurance for the duration of the child's placement in out-of-home care, and I will provide the necessary information to the DMCPS. Name of Insurance Company and / or HMO: _____
☐	☐	5.	I hereby authorize the health care provider to disclose information regarding the child's health history and status to the foster parent / relative caregiver and to the DMCPS to ensure appropriate health care and services are provided for the child.
☐	☐	6.	I hereby authorize the DMCPS or the foster parent / relative caregiver to consent to necessary disclosures of school / education records to coordinate care and services for the child.
☐	☐	7.	I hereby authorize the DMCPS or the foster parent / relative caregiver to consent to the sharing of health care information to coordinate care and services to the child.

Exceptions: State any objections to care as listed above and the reason for objecting. (Attach separate page if necessary.)

This authorization shall remain in effect for the duration of placement in out-of-home care unless withdrawn in writing.

Name – Responsible Party (Print)	**SIGNATURE** – Responsible Party	Date Signed

Name – Witness	Date Signed

* An authorization form must be filled out for every child taken into DMCPS care.
** A copy of the applicable court orders regarding guardianship must be obtained for the DMCPS file.

Distribution: Original – Case file
Pink Copy – Foster Parent / Caretaker Relative
Green Copy – Parent / Guardian

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