NO LIMITS RESIDENTIAL CARE LLC

"WE DON'T TEACH LIMITS HERE — WE TEACH POTENTIAL."

FORM 2 — GENERAL CONSENT FOR TREATMENT

Client Name: _____
Date of Birth: _____
Record Number: _____

SECTION 1 — PURPOSE OF THIS CONSENT
This consent authorizes No Limits Residential Care LLC to provide behavioral, medical, dental, and therapeutic treatment necessary for the health, safety, and emotional well-being of the child named above. This consent allows the implementation of treatment services outlined in the Person-Centered Plan (PCP).

SECTION 2 — AUTHORIZED SERVICES
A. Behavioral & Mental Health Treatment:
• Individual, group, and family therapy
• Skill-building, emotional regulation, coping strategies
• Trauma-informed interventions
• Safety planning and crisis prevention support

B. Medical & Dental Care:
• Routine medical and dental appointments
• Administration of prescribed medications
• Basic first aid, vitals, and wellness checks
• Coordination with primary care and dental providers

C. Ancillary Services:
• Nutritional support and meal oversight
• Support with health education
• Coordination with school-based or community providers if needed

SECTION 3 — LIMITATIONS
This consent does NOT authorize:
• Non-emergency surgeries
• Orthodontic or elective dental work

• Life-sustaining treatment withdrawal
• Consent to psychotropic medication changes without provider order
• Changes to educational placement/IEP decisions

SECTION 4 — GUARDIAN NOTIFICATION
Guardians will be notified of medical appointments, injuries, emergency care, and any significant changes in treatment. Failure to respond will not delay necessary care or provider-ordered treatment.

SECTION 5 — CONSENT TIMEFRAME
Valid for 1 year from signature date, or until revoked in writing, or until client is discharged.

SECTION 6 — SIGNATURES
Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

Staff Witness Signature: _____ **Date:** _____