

MEDINA COUNTY JUVENILE DETENTION CENTER

MEDICAL PERMIT

I hereby give permission to Medina County Juvenile Detention Center, and/or any physician, dentist, hospital or qualified medical personnel designated by said Center to conduct a routine physical and to perform diagnostic tests including (pregnancy tests, tuberculin skin test, venereal disease testing), medical care, surgical care, dental care, or psychological tests and services deemed necessary/ and in the best interest of my son/daughter

Name of juvenile

All tests results remain confidential and will be released only to professional agencies and individuals.

I, the undersigned, also do hereby give my consent for the release to the above agency of any and all confidential information pertaining to the diagnostic treatment, medical care, dental care, or psychological services rendered to the above named youth.

FINANCIAL RESPONSIBILITY

Print Name of Responsible Party

Signature of Responsible Party

Address

Date

City, State, Zip

HOSPITALIZATION AND/OR MEDICAL, SURGICAL, DENTAL OR OPTICAL INSURANCE

Name of Insured Party: _____

Employer: _____

Insurance Company: _____

Policy Number: _____

List any Allergies to food or medication: _____

Were Childhood Immunizations Completed? ____ Yes ____ No

Has this child had a tetanus immunization in the last 10 years? ____ Yes ____ No

Signature of Parent

Date