MEDICAL CONSENT AUTHORIZATION

_____ currently resides in a home based community residential setting operated by
Member
Family Touch LLC. I hereby give authorization to _____, the residential service
ADH/CDH/Respite Provider(s)
provider(s) to provide the following medical care for _____:
Member

☐ Yes ☐ No Routine medical consultations, evaluations, assessments, testings and treatments;

☐ Yes ☐ No Necessary urgent care or emergency medical treatment with the understanding I must be informed and will authorize any serious medical treatment.

☐ Yes ☐ No Procure prescription and over-the-counter medications;

☐ Yes ☐ No Administer prescription and over-the-counter medication per doctor's orders and written instructions;

☐ Yes ☐ No Routine dental care; and

☐ Yes ☐ No ☐ N/A The ongoing or recurring use of a protective device in response to a medical condition with authorization from a medical practitioner, the consent of the responsible person, and under direction and review by the ISP team.

Type of Protective Device(s): _____

If 'no' is selected for any of the above, the responsible person agrees to provide for the necessary medical and dental care for member.

I certify the preceding has been explained to me and I understand it fully.

_____ _____
Signature of Responsible Person Date