Hardin County Juvenile Court
One Courthouse Square Suite 200
Kenton, OH 43326

JUVENILE PROBATION
400 Decatur Street
Kenton, OH 43326
419-673-3210
David Lawrence ex. 1006 **Amy Kissling ex. 1010**
Holden Manns ex.1003 **Julian Brown ex.1009**
Leaha Archer ex. 1004 **Community Control Managers**

Notice to Physician

To Whom It May Concern,

_____ is taking part in a **COURT ORDERED JUVENILE PROBATION PROGRAM**. As part of this program, participants must satisfy certain criteria regarding: MEDICAL TREATMENT, RANDOM ALCOHOL AND OTHER DRUG SCREENS, as well as DAILY SCHOOL ATTENDANCE. Please mark the appropriate box(s) as the statement applies to your patient. Your cooperation and participation in the treatment of this child is greatly appreciated. It is extremely important for this child to be in school and avoid prescription drugs that are subject to abuse.

Thank you,

The Honorable Steve D. Christopher
Hardin County Court of Common Pleas
Juvenile Division
One Courthouse Square Suite 200
Kenton, Ohio 43326
(419) 674-2233

Hardin County Juvenile Court Staff

PHYSICIAN'S STATEMENT ** must fill out completely**

** Date of Appointment _____ Time of Appointment_____

❑ **This patient is too ill to perform his/her job (attend school and treatment) from _____, 20___ to _____, 20____. (This must be specific.) Return On _____, 20_____.**

❑ **Patient should return to school immediately following appointment.**

Must give reason to be accepted

❑ **Medical Reason for Absence:_____**

❑ This patient has advised me of the patient's participation in the Court's RANDOM ALCOHOL AND OTHER DRUG SCREENS; however, it is my medical opinion that scheduled medication/narcotic/and other drug susceptible to abuse is necessary and the child's immediate medication needs **outweigh the risk of substance abuse**. Non-scheduled medication and other treatment are insufficient to meet this child's medical needs. **The child's custodian has agreed to monitor medication compliance and secure the medication.**

Medication prescribed_____ for _____days.

Medication prescribed_____ for _____days.

❑ This patient requires isolation or quarantine. Diagnosis: _____ and may return to school and treatment on: Date:_____.

Physician's Name (PRINTED) _____

Physician Signature_____ DATE:_____

Physician's phone number for confirmation purposes_____

I hereby authorize the release and or exchange of the above identifying information from my records I hereby release the physician from all legal responsibility or liability that may rise from this authorization. This release will remain in effect until withdrawn.

Parent / Client Signature _____ *DATE:* _____

Custodian Signature _____ *DATE:*_____

Notice to Physician Revised 01/11/10