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Sampson County CAC

204 Sampson Street, Clinton, NC 28328

910-490-9100

**Consent for Treatment**

**Name of Child**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

 Last Name First Name M.I.

**Child’s Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MM/DD/YYYY

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have authority to consent to evaluation and treatment of the above-named minor child as:

|  |  |
| --- | --- |
| \_\_\_\_ | The child’s parent |
| \_\_\_\_ | The child’s legal guardian or custodian |
| \_\_\_\_ | DSS Director acting pursuant to a court order authorized by N.C.G.S. 7B-505.1(b) |

I do hereby authorize Sampson County Child Advocacy Center, Inc. to perform the following on the child named above:

|  |  |
| --- | --- |
|   |  |
| \_\_\_\_ | Forensic interview |
|  |  |
|  |  |

By signing below, I give permission to the named provider to perform the evaluation(s) above, portions of which will include photographs and/or video, and to administer any treatment deemed necessary or advisable in the diagnosis and treatment of the child named above.

I acknowledge that the evaluation is used in making decisions regarding allegations of child physical abuse, sexual abuse and/or neglect.

For cases referred by the Department of Social Services (DSS), I understand that the findings of the Child Medical Evaluation or Child/Family Evaluation will be released to the County Department of Social Services, the Child Medical Evaluation Program and any agency or individual deemed necessary by DSS.

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Signature of Person Authorized to Consent Relationship to Child Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date