

**MEDICAL AUTHORIZATION AND RELEASE**

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. **EMERGENCY TREATMENT, ROUTINE HEALTHCARE, ROUTINE DENTAL CARE:** I hereby authorize Tennyson Center for Children to take the above named child to a physician or hospital in the case of an accident, injury, or illness, which requires immediate medical attention. I further authorize staff to sign for medical treatment of the above-mentioned child and release pertinent medical information to those involved in providing the routine and/or emergency treatment.

I hereby consent to any emergency surgical and dental treatment for said child after having made reasonable efforts to contact the county Department to obtain its consent.

**The County Department shall be notified no later than the following working day of any administration of emergency services or surgical services provided under this authorization.**

I understand that the Legal Guardian of this child will ultimately be held accountable for any unresolved medical statements/care or they will be paid through the \_\_\_\_\_ **Insurance Plan.**

**Policy Number:** \_\_\_\_\_

2. **OVER THE COUNTER MEDICATIONS:** Colorado Department of Human Services licensing regulations **prohibit Tennyson Center for Children staff from providing or administering any over-the-counter medication to a child in the absence of an order from a physician.** As a result, the agency cannot give a child non-prescription medications (including but not limited to aspirin, Tylenol, ibuprofen) or use antibiotic ointments or topical creams for first aid purposes without the approval of a physician.

The child's physician may be willing to furnish the Tennyson Center for Children with a "standing order" authorizing the administration of specified over-the-counter medications that would be consistent with the child's medical condition and current use of prescription medications. **It is the sole responsibility of the undersigned to obtain any such written standing order and to provide it to the agency. (The physician's office may fax the order directly to the agency at 303-433-9701.)**

3. **PRESCRIPTION MEDICATION AND IMMUNIZATIONS:** I give my permission for authorized Agency staff to administer to the above named child the previously prescribed medication, \_\_\_\_\_, and/or to administer said medication as prescribed by the consulting physician, together with any immunization as required/recommended by state health standards (CDC – Center for Disease Control), in accordance with Agency policy. *\*\*Please note that children in the residential treatment program who are taking prescription medication are medically evaluated on a regular basis by the consulting physician.*

This **Medical Authorization and Release** shall remain effective during any time the child is receiving services from Tennyson Center for Children. This Release and Authorization may be revoked or modified at any time by providing written notification to the Agency's Chief Program Officer.

<b>Parent/Guardian</b>	<b>Relationship to Child</b>	<b>Date</b>
<b>Parent/Guardian</b>	<b>Relationship to Child</b>	<b>Date</b>
<b>Client</b>	<b>Date</b>	<b>Witness</b>
<b>Client</b>	<b>Date</b>	<b>Date</b>
<b>Caseworker</b>	<b>Date</b>	