NORTHWEST REGIONAL JUVENILE DETENTION CENTER
CONSENT FOR MEDICAL TREATMENT FORM

JUVENILE' NAME: _____DATE OF BIRTH: _____/_____/_____

PARENT/GUARDIAN'S NAME: _____

I agree to the following procedures in the event there is a need for medical examination or treatment of my child, who is being detained at the Northwest Regional Juvenile Detention Center.

I. CONSENT FOR TREATMENT: I understand that a reasonable effort will be made to contact me at the phone number(s) listed below to obtain my consent for necessary medical treatment, including surgical procedures, prior to initial treatment. The Northwest Regional Juvenile Detention Center will make reasonable efforts to try and locate me until I have been contacted.

A. If I cannot be located, the Northwest Regional Juvenile Detention Center staff may use this consent for medical treatment form to authorize necessary treatment and/or hospitalization.
B. I understand that the Eau Claire County Juvenile Court may authorize medical services including surgical procedures when needed pursuant to Wis. Stats. § 938.373.
C. All medical treatment will be provided under the direction of a licensed physician, surgeon or nurse.
D. This consent for medical treatment will remain in effect for a period of One (1) Year from date of signature unless I revoke it or otherwise withdraw my consent, which I may do at anytime by providing written notice to the Northwest Regional Juvenile Detention Center. This consent will remain in effect for the period of one year even if my child is discharged and then returns to the Northwest Regional Juvenile Detention Center. This consent form will remain in effect even if there are changes in my child's medication or dosages, and or other treatment, but I understand that all reasonable efforts will be made on the part of the Northwest Regional Juvenile Detention Center to contact me as soon as reasonably possible after the changes occur.

II. MEDICATION DISBURSEMENT: I understand that it is the policy of the Northwest Regional Juvenile Detention Center to verify all medication prescriptions before distributing them. Verification of prescriptions will be done through consultation with the prescribing physician, local pharmacy and /or the facility nursing staff.

A. I give my consent for the Northwest Regional Juvenile Detention Center to distribute over-the-counter medications such as Tylenol, Ibuprofen, aspirin, etc, for customary medical care, and I also give consent for the distribution of prescribed medications for customary care or for the treatment of a chronic illness such as asthma, diabetes, etc.
B. I give my consent for the Northwest Regional Juvenile Detention Center to distribute prescribed **psychotropic medication** according to the treating physician's directions. I may withdraw my consent to for the administration of psychotropic medication at any time by providing written notice to the Northwest Regional Juvenile Detention Center. I also understand that pursuant to Wisconsin Statutes that if my child is 14 years of age he or she may request and consent to the taking of psychotropic medications even if I withhold my consent (§ 938.505).

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

IMPORTANT: If your child is eligible for Medical Assistance/ Badger Care, is already covered by Medical Assistance/ Badger Care or private medical insurance, please send a copy of the Medical Assistance card or number with your child. If that is not possible, you may contact the detention center at any time or provide any staff member with the number. The number will only be used in the event your child needs medical treatment or medication (715) 839-6086.

PLACES WHERE I CAN BE REACHED IN CASE OF AN EMERGENCY:

Home Address: _____ Home: _____ Cell: _____

Work Name and Address: _____ Work: _____

Alternate Contact: _____ Home: _____ Cell:_____