# LIMITED CONSENT FOR EVALUATION AND TREATMENT

**NAME OF YOUTH:** _____

**DJJID #:** _____ **MEDICAID #:** _____
(AS APPLICABLE)

**THIS AUTHORITY IS LIMITED AS FOLLOWS:**

## QUALITY OF TREATMENT

A) The child will be examined and medically treated only by persons who are properly qualified to perform such examinations and provide such treatment with exception to defined circumstances as stated herein.

B) Any treatment authorized by the Department must be recommended by a person licensed in Florida and permitted under Florida law to make such a recommendation.

C) Any treatment authorized by the Department must be recommended in accordance with the medical or mental health standards in the community where the treatment will take place.

## WHAT THIS CONSENT COVERS

1. Physical examinations conducted in accordance with the usual accepted medical standards of the community. These examinations may include:
   a) Determining whether the child is currently suffering from any illness or disease or has any problems that require medical treatment while the Department has the youth in its physical custody.
   b) Obtaining a complete medical and mental health history from the child, including information about past illnesses, hospitalizations, etc.
   c) Testing for drug and/or alcohol abuse.
   d) Blood, urine, tuberculosis and other laboratory tests that may be done as part of a complete physical examination.
   e) Examining the child for any dental problems, and providing emergency dental care and treatment.
   f) Testing the child's vision and hearing.
   g) Gynecological examination.
2. Give permissions to a licensed health care provider to give the child additional tests that he or she thinks are necessary as a result of a physical examination.
3. Obtain necessary medical and clinical treatment for any illness or disease that the child has now or develops while he/she is in the Department's facility.
4. Regarding mental health or emotional illnesses that the child now has or develops while in the custody of a Department facility, the Department may arrange for, make available and facilitate mental health assessments and treatment with licensed mental health care providers or mental health facilities, including diagnostic assessment, psychological testing, and individual, group, and family therapy and/or counseling, except as otherwise provided in this section. This section shall not be read as authorizing my consent to the commitment of my child to a residential facility licensed under Chapter 393, Florida Statutes (Developmental Disabilities) or Chapter 394, Florida Statutes (mental health), but is acknowledging commitment under Chapter 985, Florida Statutes. If hospitalization in a mental health facility is recommended, I will be notified in advance, and will have the opportunity to object if I wish to.
5. Obtain prescription medications that are currently prescribed, excluding psychotropic medications, for the child.
6. Regarding vaccinations/immunizations, the Department may provide the standard vaccinations, if the child has not had them and/or if they are not up to date and/or if they are required to attend school in Florida, such as for tetanus, measles, polio, and Hepatitis B and after review of the necessary information about the immunization(s).
7. I authorize licensed health care and non-health care staff members to provide antipyretics, non-steroidal anti-inflammatory medications (excluding Aspirin), anti-indigestion medications, antacids, Triple Antibiotic Ointment and antihistamines for the purpose of allergic reactions only. All of these medications shall be administered in accordance with the manufacturer's recommended dosage, to the child for minor physical complaints. I understand that the child will receive a medical evaluation for minor complaints that are unrelieved by these over-the-counter medications. I understand that all other over-the-counter medications will be provided pursuant to a Physician's approval.
8. *ACCESS TO RECORDS. The Department shall have access to all records of whatever nature concerning the mental and physical health of the child. I direct that any and all health care providers, whether involved in mental or physical health care, shall provide all records concerning the child to the Department at the request of the Department and/or its authorized agents. These records also include any evaluations, assessments, and/or treatments of the child provided in the future, while the child is in the custody of the Department.* ***It is my intent that this document acts as the consent and release of these records to the Department and/or its authorized agents.***

## WHAT THIS CONSENT DOES NOT COVER

1. I understand this Consent applies only when the child is staying 24 hours a day at a Department detention facility.

2. The Department has the right to choose the health care provider as long as the person is properly qualified in Florida. However, in certain instances, the Department may be able to utilize the child's usual provider, particularly if this is convenient for the facility, and the provider agrees to do so.

3. This signed consent does not provide authorization for substance abuse treatment. The child must provide his or her consent to this treatment.

4. This signed consent does not authorize the provision of psychotropic medications.

## ACKNOWLEDGEMENTS

☐ I am consenting to necessary vaccinations. I have received the following Vaccine Information Sheet(s) :_____(list here)

**DATED THIS _____ DAY OF _____, 20____.**

**FOR YOUTH NOT IN THE DEPENDENCY SYSTEM:**
**THE PARENT OR GUARDIAN COULD NOT BE CONTACTED AFTER A DILIGENT SEARCH. THE JPO SHALL ATTACH AN AFFIDAVIT OF DILIGENT EFFORT (HS 056), AND THE FACILITY SUPERINTENDENT OR ASSISTANT MAY SIGN. A FULL AUTHORITY FOR EVALUATION AND TREATMENT (HS 002) SHALL BE OBTAINED AS SOON AS POSSIBLE, WHICH SHALL SUPERSEDE THIS LIMITED CONSENT.**

_____ _____
**DETENTION FACILITY SUPERINTENDENT (SIGNATURE)** **WITNESSED BY: DJJ REPRESENTATIVE (SIGNATURE)**

_____ _____
**DETENTION FACILITY SUPERINTENDENT (PRINTED)** **DJJ REPRESENTATIVE (PRINTED)**

**FOR YOUTH IN THE DEPENDENCY SYSTEM WHO REMAIN IN THE HOME OF PARENT OR GUARDIAN:**
**WHERE THE PARENT OR GUARDIAN COULD NOT BE CONTACTED AFTER A DILIGENT SEARCH, THE JPO SHALL ATTACH AN AFFIDAVIT OF DILIGENT EFFORT (HS 056), AND THE FACILITY SUPERINTENDENT OR ASSISTANT MAY SIGN.**

_____ _____
**PARENT OR GUARDIAN (SIGNATURE)** **WITNESSED BY: DJJ REPRESENTATIVE (SIGNATURE)**

_____ _____
**PARENT OR GUARDIAN (PRINTED)** **DJJ REPRESENTATIVE (PRINTED)**

**OR**

_____
**DETENTION FACILITY SUPERINTENDENT (SIGNATURE)**

_____
**DETENTION FACILITY SUPERINTENDENT (PRINTED)**

**FOR YOUTH IN THE DEPENDENCY SYSTEM WHO ARE IN OUT-OF-HOME CARE:**

**THE JPO SHALL CONTACT THE DEPARTMENT OF CHILDREN AND FAMILIES OR ITS CONTRACTED SERVICE PROVIDER TO OBTAIN LIMITED CONSENT FROM THE PARENT, THE DEPARTMENT OF CHILDREN AND FAMILIES, OR THE OUT-OF-HOME CAREGIVER, AS REQUIRED BY THE COURT'S ORDER OF PLACEMENT.**

PARENT OR GUARDIAN (SIGNATURE)

WITNESSED BY: DCF REPRESENTATIVE (SIGNATURE)

PARENT OR GUARDIAN (PRINTED)

DCF REPRESENTATIVE (PRINTED)

OR

DCF CASE MGR. / CONTRACTED PROVIDER (SIGNATURE)

DCF CASE MGR. / CONTRACTED PROVIDER (PRINTED)

OR

OUT-OF-HOME CAREGIVER (SIGNATURE)

OUT-OF-HOME CAREGIVER (PRINTED)

**FOR YOUTH IN THE DEPENDENCY SYSTEM WITH A TERMINATION OF PARENTAL RIGHTS:**

DCF CASE MGR. / CONTRACTED PROVIDER (SIGNATURE)

WITNESSED BY: DJJ REPRESENTATIVE (SIGNATURE)

DCF CASE MGR. / CONTRACTED PROVIDER (PRINTED)

DJJ REPRESENTATIVE (PRINTED)