AUTHORITY FOR EVALUATION AND TREATMENT (AET)

NAME OF YOUTH: _____

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

I, _____, THE PARENT OF _____

OR I, _____, AS THE GUARDIAN OF _____

("MY CHILD") DO HEREBY APPOINT THE DEPARTMENT OF JUVENILE JUSTICE, OR ITS AUTHORIZED AGENT (COLLECTIVELY, "THE DEPARTMENT"), AS MY REPRESENTATIVE FOR THE PURPOSES SET OUT IN THIS DOCUMENT. I AUTHORIZE THE DEPARTMENT TO MAKE THE DECISIONS CONCERNING MY CHILD'S ROUTINE PHYSICAL AND MENTAL HEALTH TREATMENT, AS DESCRIBED IN THIS DOCUMENT. I UNDERSTAND THAT THIS DOCUMENT APPLIES ONLY UNTIL MY CHILD REACHES THE AGE OF 18. AT THAT TIME MY CHILD WILL CONSENT FOR TREATMENT FOR HIS/HER SELF.

A LETTER OF GUARDIAN SHOULD BE PRESENTED FOR CLAIM OF GUARDIAN TO YOUTH

STATE: _____ COUNTY: _____ DATE: _____

THIS AUTHORITY IS LIMITED BY ME AS FOLLOWS:

QUALITY OF TREATMENT

A) My 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.

THE DEPARTMENT MAY AUTHORIZE THE FOLLOWING ON MY BEHALF:

WHAT THIS AUTHORITY COVERS

1. Physical examinations of my child conducted in accordance with the usual accepted medical standards of the community. These examinations may include:
   a) Determining whether my 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 my 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 my child for any dental problems and providing emergency dental care and treatment.
   f) Testing my child's vision and hearing.
   g) Gynecological examination.
2. Give permissions to a licensed health care provider to give my 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 my child has now or develops while he/she is in the Department's facility or program.
4. Regarding mental health or emotional illnesses that my 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 have been ordered for my child. If a new prescription medication has been recommended or started for my child, or a medication my child was currently receiving has been ordered to be stopped, or if there is a significant change in the dosage of a medication my child was/is receiving, attempts will be made to contact me by telephone prior to making any of these changes, unless it is felt necessary to start the medication immediately. Notices of medication changes will be sent to me at the address I have provided in this document. I understand that if my address or mailing address changes, I must contact my child's Juvenile Probation Officer and the facility where my youth is detained or residentially committed and inform them of the address change.

6. I understand that I can object to medication changes by calling the facility and speaking to the person listed on the notice. I further understand that I should also object in writing to the facility listed on the notice sent to me.

7. Regarding prescription medications for mental or emotional problems that may be ordered or changed, I understand that reasonable attempts will be made to contact me verbally/by telephone prior to making the changes in order to explain the medications and that a detailed notice about these medications will also be sent to me. I understand that I am to sign a permission form and mail it back to the facility.

8. Regarding vaccinations/immunizations, the Department may provide the standard vaccinations, if my 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 if I have been provided the necessary information about the immunization(s) and have provided my written consent. The Department may authorize and provide flu shots when recommended by a licensed health care provider if I have been provided the necessary information about the immunization and have provided my written consent. If I have been provided with the Vaccination Information Sheets at the time of this Consent, this form will serve as my permission for administration of the vaccines. Otherwise, I will be notified in advance of administration of these vaccinations and asked for my permission prior to giving them to my child.

9. I understand that my child may be assisted with the self-administration of routine medications, (depending on the DJJ facility), by trained/qualified staff who are not health care professionals but will provide these medications based on procedures that have been approved by the physician who provides oversight to the program and/or provides care to the youth.

10. I authorize licensed health care and non-health care staff members to provide Acetaminophen (Tylenol), Ibuprophen (Motrin), anti-indigestion medications (e.g. Pepto Bismol), antacids (i.e., Milk of Magnesia, Maalox), Triple Antibiotic Ointment and Diphenhydramine (e.g. Benadryl) for the purpose of allergic reactions only. All of these medications shall be administered in accordance with the manufacturer's recommended dosage, to my child for minor physical complaints. I understand that my 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.

11. *ACCESS TO RECORDS. The Department shall have access to all records of whatever nature concerning the mental and physical health of my child, to the same extent that I have would have access to them. I understand that my child may be seen by multiple health care providers, including those that see my child at the facility and those to whom my child is taken for treatment. To that end, I direct that any and all health care providers, whether involved in mental or physical health care, shall provide all records to which I would be entitled concerning my child to the Department at the request of the Department and/or its authorized agents. These records shall include, but not be limited to, records of any and all past evaluations, assessments and/or treatment of my child, and any and all past prescriptions ordered for my child. These records also include any evaluations, assessments, and/or treatments of my child provided in the future, while my child is in the custody of the Department.* ***It is my intent that this document acts as my consent and release of these records to the Department and/or its authorized agents.***

WHAT THIS AUTHORITY DOES NOT COVER

1. I understand this Authority applies only when my child is staying 24 hours a day at a facility run by or supervised by the Department. I am responsible for my child's health care in any other circumstance. If my child is in a facility-based non-residential program run by or supervised by the Department, it also gives the Department authority to (a) administer prescription medications that I bring to the program, and (b) provide any emergency treatment. I understand that I am responsible for my child's health care in any other circumstances.

2. I understand that I cannot choose the physician or other health care provider that will treat my child. 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, I can ask the Department to utilize my child's usual provider, particularly if this is convenient for the facility, and the provider agrees to do so.

3. I can refuse to sign this document. I can limit the scope of this document by advising the Department in writing of specific

procedures I will not authorize. In addition, I can take back the permission that I have given in this document at any time either in part or completely, by calling or writing the facility where my child is located or the person who is providing the care.

4. I understand that if I refuse to sign this document or if I take back the permission granted by it, the Department has the right to ask a court order to give the Department permission to provide treatment. I will have an opportunity to present my concerns to the Judge before he or she decides about my child's care.
5. The Department will keep me advised of my child's mental and physical health status when warranted. Notices will be sent to me at the address I have listed in this document. It is my responsibility to inform the Department of any change in the address.
6. I understand that if my child requires substance abuse treatment that my child must provide his or her consent to substance abuse treatment and that my signature on this document does not provide authorization for this treatment.

ACKNOWLEDGEMENTS

I declare that I have read and understand the terms of this document. All questions I have concerning the powers I have given the Department in this document have been answered to my satisfaction. No one has made any threats in order to get me to sign this document.

INITIALS

☐ I am consenting to necessary vaccinations.

☐ I have received the following Vaccine Information Sheet (s): _____ (list here)

☐ I am refusing Vaccinations due to religious reasons. I understand I must now complete "The Religious Exemption From Immunization" Form (at the County Health Department) and have it signed and authorized by their Administrator and submit a copy to the Department of Juvenile Justice.

☐ I am refusing Vaccinations due to medical reasons. I understand I must now submit a Physician's statement to the Department stating why the vaccinations are contraindicated.

☐ I am refusing to sign the Authority for Evaluation and Treatment form.

Reason: _____

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

_____ _____

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

_____ _____

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

ADDRESS: _____

PHONE NUMBER: _____ **(HOME)**

PHONE NUMBER: _____**(CELL)**

PHONE NUMBER: _____**(WORK)**