Alaska Department of Health & Social Services
Office of Children's Services

CONSENT FOR EMERGENCY AND ROUTINE MEDICAL CARE

_____is hereby authorized to give permission for _____
(Out of Home Care Provider's Name) (Child's Name)

DOB:_____ to receive emergency medical, surgical, dental, or optical care and routine medical, dental, or optical care, including check-ups, immunizations, and/or treatment for minor illnesses and accidents.

This signed form authorizes the out of home care provider to administer non-prescription and commonly used over-the- counter medication in accordance with the manufacturer's label.

In an **emergency** this form also authorizes the care provider to immediately seek medical assistance for the child. When the incident is life threatening or requires hospitalization the care provider immediately **informs the assigned OCS worker,** so that the child's parents or the court can be contacted.

NOTE: Non-emergency major medical care is not covered by this consent. A separate authorization is required. Examples include:

- non-emergency surgery
- psychotropic medication or any drugs prescribed for mental illness or behavioral problems.

☐ Provider may contact parent directly in addition to notifying the placement worker. ☐ Mother ☐ Father

Mother _____ Home Phone _____ Work Phone _____

Father _____ Home Phone _____ Work Phone _____

If practical, the following Medical Providers should be used: Doctor: _____ Phone _____

Therapist:_____ Phone_____ Dentist: _____ Phone _____

Date Last Physical Exam:_____ Conducted by: _____ Phone _____

Child's Allergies, including drugs, any medication the child is taking or medical treatment the child requires: _____

_____

If known, immediate and long term medical or therapeutic needs: _____

☐ Immunization Record attached. If not attached, location of child's record, if known: _____

Child covered by medical insurance_____ policy #_____ ☐ parent funds _____
(insurance co.) (parent)

Child determined eligible for Medicaid ☐ Yes ☐ No **MEDICAID NUMBER** _____ ☐ ANHS eligible

☐ Medicaid has been applied for. Until approval is received, forward medical bills to the OCS worker at address below.

The medical provider is permitted to provide necessary medical information to the payor.

_____ _____ _____
(Signature of Assigned OCS Worker) (Title) (Date)

Authority: AS 47.10.084, AS 47.14.100, AS 47.32, 7 AAC.50.140(c) & (d), 300(a) & (g), 320(h), 7 AAC 53.320.

Distribution: Original: Care Provider
Copy: OCS file

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