INTEGRATED WELLNESS SOLUTIONS

Consent for Medical Examination and/or Treatment – Juveniles

Name:	ID#:	DOB
Date/Time:	Allergies:	Gender:

Parent/Guardian 1

Name: _____ Relationship: _____

Address: _____

Phone: (cell) _____ (home) _____ (work) _____

Parent/Guardian 2

Name: _____ Relationship: _____

Address: _____

Phone: (cell) _____ (home) _____ (work) _____

Medical/Mental Health/Dental Care Consent

By signing below, I grant consent of Integrated Wellness Solutions or other licensed providers designated by IWS to provide general medical, mental health and dental treatment for the above-named minor during his/her incarceration at the Juvenile Detention Facility.

By signing this consent, I permit the qualified health providers and staff to treat my son/daughter/ward. This consent is intended for the following:

- Treatment for common and urgent medical conditions, including the prescription of medication, conditions such as cold/flu, asthma, diabetes, infections, strains or fractures that do not require surgery.
- Treatment for mental health conditions, counseling and psychotherapy.
- Treatment for dental conditions such as fractures, dental abscess, dental filling, root canal and local anesthesia, etc.

I authorize the Chief Probation Officer or his designee to complete any specific authorization forms required to provide the general medical, mental health and dental treatment described above.

I understand that a separate consent or court order will be required for:

- The administration of psychotropic drugs to the above-named minor.
- Significant, planned medical/surgical procedures such as general surgery, bone fracture surgery, blood transfusion, dental extraction (pulling teeth), etc.

The restriction does not limit the ability of the qualified health providers and staff to treat immediate, emergency or life threatening medical, mental health or dental conditions needed to alleviate pain or suffering of my son/daughter/ward. The Chief Probation Officer or his designee is authorized to sign whatever forms are required by the treatment provider to obtain the emergency treatment. It is understood that every effort will be made to contact me to inform me of the need for immediate treatment as soon as it is feasible.

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Name:	ID#:	DOB
Date/Time:	Allergies:	Gender:

Vaccine Screening & Immunization Consent

I have been given a copy and have read, or had explained to me, the information contained in the vaccine Information Statement(s) about the vaccine(s) necessary to bring my son's/daughter's/ward's immunization up to date according to the guidelines of the American Academy of Pediatrics and Center for Disease Control, and I understand the benefits and risks of vaccinations. I give my permission for my son/daughter/ward to receive immunizations required by the state for school attendance or recommended by the American Academy of Pediatrics. If I have questions regarding immunizations, I understand that I may call Juvenile Hall Medical Services.

A copy of this document, consisting of two (2) pages, shall have the same force and effect as the original. This consent shall be valid for three (3) years from the date listed below.

_____ _____

Signature (Parent/Guardian/Authorized Representative) Date/Time

_____

Print Name

***Note- Under local state and federal law, parental consent may not be required for treatment of some specific conditions including: contraception, sexually transmitted infection services, prenatal care, adoption, abortion and medical care of the minor's child. In those situations, the minor may consent to their own care and may be required to consent for notification to be made to the parent/guardian.*

INTEGRATED WELLNESS SOLUTIONS

Authorization for Use or Disclosure of Protected Health Information

Name:	DOB:	ID#:
Date/Time:	Allergies:	Gender:

Completion of this document authorizes the disclosed and/or use of individually identifiable protected health information (PHI). All sections of the form must be completed to be valid.

I authorize:

_____

(Name/Address)

_____

(Phone/Fax)

To disclose my health information to:

Name/Company: Tulare Co Juvenile Detention Facility–Integrated Wellness Solutions

Address: 11200 Ave 368, Visalia, CA 93291

Phone/Fax: 559-735-1362 / 559-732-1962

Description of Information to be released:

_____ All Records (excluding protected class)
_____ Discharge Summary
_____ Pharmacy records
_____ Other: _____

Protected Class Information: Special approval is required before protected classes of information can be released. These types of records may or may not be contained in the medical record. This information will be disclosed only if I place my initials in the applicable space next to the type of information:

_____ Drug and Alcohol Records, diagnosis, treatment or referral information

_____ Mental Health Records, including provider notes

_____ HIV/AIDS related information and testing

_____ Genetic testing information

The purpose or need for the disclosure of this information is:

_____ Treatment or Consultation _____ At patient request _____ Other: _____

This authorization will be valid for the time below unless it is revoked in writing by the patient.

_____ One (1) year from signature date _____ Completion of this request (one time disclosure)

_____ On specific date _____ _____ Other: _____

You may revoke this authorization in writing at any time by sending a notice canceling this authorization to the provider(s) listed on page 1 of this form. Cancellation of this authorization will not apply to information already released based on this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPPA). *(California law prohibits recipients of these records from re-disclosure unless another authorization for such disclosure is obtained, or unless disclosure is specifically required or permitted by law.)*

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or to enroll or be eligible for benefits.

Fees may be charged for copy services.

_____ _____

Signature of Individual Date

_____ _____

Signature of Authorization Representative Date

Relationship: ____Parent ____Guardian ____Conservator ____Other:_____

INTEGRATED WELLNESS SOLUTIONS

Dental Consent for Exam & X-Rays

Name:	ID#:	DOB:
Date/Time:	Allergies:	Gender:

I consent to the exam and dental x-rays that are necessary and advisable and treat the planned service or services. The benefit of an exam and x-rays is to find hidden problems and to provide a more complete diagnosis which will help determine a more effective treatment plan. Postponing an exam or x-ray may result in worsening dental conditions or missing potential problems.

By signing this, I acknowledge that I have read and have been given the opportunity to ask questions before signing this form. I have given a complete and truthful medical history, including all medications, drug use, pregnancy, etc. And I understand by signing this form, I give my consent for exam and x-rays.

Patient Signature: _____ Date/Time: _____

Parent/Guardian Signature: _____ Date/Time: _____

Witness Signature: _____ Date/Time: _____

I have explained the matters indicated above relating to the procedure including the risks, consequences and alternatives. The patient appeared to understand and consented to the procedures described.

Dental Provider Signature: _____ Date/Time: _____

Dental Provider Printed Name/Title: _____

INTEGRATED WELLNESS SOLUTIONS

Dental Consent for Permanent Filling

Name:	ID#:	DOB
Date/Time:	Allergies:	Gender:

Permanent Filling(s) for Tooth Number(s)/Area _____ **Patient's Initials:** ____

Benefits of Procedure	Possible Complications	Consequences of Postponing Treatment
• Eliminates decay • Relieves pain • Covers eroded or broken areas	• Tooth may abscess from filling • Filling may fall out • Tooth may be heat and/or cold sensitive	• Tooth may fracture • Pain will increase • Decay may get large and cause an infection
Benefits of Anesthesia	**Possible Complications of Anesthesia**	
• Avoid pain during treatment	• Gum irritation or bruising • Prolonged numbness or nerve damage • Allergic reaction	

It has been recommended that the above listed tooth/teeth need a permanent filling(s). Generally, restorations are used to repair teeth that have been structurally compromised by neglect, previous restorations, decay or to protect a tooth that has a root canal, etc.

The tooth/teeth may need to be prepared to receive permanent restoration. This may require some of the tooth/teeth being removed with a hand piece and water spray. On occasion, the pulp (nerve and blood supply inside the tooth) may be irritated by the preparation process, prior trauma or decay and may begin to cause pain. If this persists, your tooth may need an extraction or root canal upon being released from the facility. It is likely that not all of the decay will be removed if it is seen that the nerve will be disturbed. A permanent restoration will be placed to protect the tooth and permit chewing. The tooth/teeth will be checked for proper fit and harmony with the bite to be comfortable. It is possible to experience a sensation that the restoration is "too high" or "different" until you become accustomed to it.

By signing this, I acknowledge that I have read and understand the treatment listed above and have been given the opportunity to ask questions before signing this form. I have given a complete and truthful medical history, including all medications, drug use, pregnancy, etc. and I understand by signing this form, I give my consent for the permanent filling procedure as well as the use of local anesthesia.

Patient Signature: _____ Date/Time: _____

Parent/Guardian Signature: _____ Date/Time: _____

Witness Signature: _____ Date/Time: _____