DCF-460a
07/2011 (New)

STATE OF CONNECTICUT
Department of Children and Families

PERMISSION TO DELIVER OR OBTAIN ROUTINE HEALTH CARE

TO BE GIVEN TO THE CAREGIVER AT THE TIME OF PLACEMENT

DATE_____

Name of Child:	DOB:	Medical Insurance Info:	Legal Status:
Placement Contact Name/Address/Phone Number:			
Area Office Worker:	Phone/Fax:	Supervisor Name:	Phone/Fax:

On behalf of the above-named child, permission is given to deliver or obtain routine health care as follows:

- EPSDT services, which are age-appropriate periodic screenings and, when indicated, diagnosis and treatment, including comprehensive history and physical examination; appropriate immunizations, laboratory tests, health education and anticipatory guidance; and vision, hearing and dental services;
- follow-up and monitoring of chronic medical conditions
- treatment of common childhood diseases
- completion of camp physicals and forms
- completion of school forms

THE UNDERSIGNED, HAVING THE AUTHORITY TO CONSENT ON BEHALF OF THE MINOR NAMED ABOVE, AND HAVING REVIEWED THE EXPLANATION PROVIDED BY THE QUALIFIED HEALTH CARE PROVIDER, HEREBY CONSENTS TO SUCH PROCEDURE OR TREATMENT.

Parent's Name and Signature (if child/youth under an OTC):	Date:
DCF Designee: Name/Title	
DCF Designee Signature:	Date:
Location: DCF Area Office/Facility/Other	