Grayson County Department of Juvenile Services
MEDICAL AND MEDICATION AUTHORIZATION

I, the undersigned parent/legal guardian of _____, hereinafter referred to as "my child", do hereby authorize and extend permission to the Grayson County Department of Juvenile Services, Grayson County, it's officers, agents, and employees, hereinafter referred to as "the Facility" to authorize and provide medical and mental health care for my child.

I do hereby authorize any doctor and/or medical or mental health facility selected by the Facility to render any and all necessary medical and/or mental health services to and for my child, including but not limited to examinations, injections, surgery and isolation for any contagious disease, and individual psychotherapy.

I do hereby authorize any medical and psychiatric care, including but not limited to being seen/evaluated by a psychologist, psychiatrist, therapist and/or admittance into an in-patient psychiatric hospital.

I do hereby authorize the facility staff to administer prescription medication to my child as ordered by a physician. I understand that non-prescription medication will not be allowed unless approved by the administration of the Facility.

I do understand that any cost incurred from the doctors or the hospital in which my child is referred is my responsibility. I also understand that any cost of prescription medication my child is ordered to take is also my responsibility.

I do hereby agree to save, hold harmless and indemnify the Facility of and from any and all claims, demands and causes of action whatsoever on account of or in any way resulting from or to result from the authorizing by the Facility of any such medical services or administration of prescription medication.

_____ _____
Parent/Guardian Signature Date

_____ _____
Printed name Witness

_____
Home address of Parent /Guardian

_____
Telephone/Cell

Insurance Information: **Please provide copy of front and back of card**

Insurance Company _____
Member's name and DOB_____
Policy and Group #_____

Medical history to be completed by parent (prior to physical)

	Yes	No		Yes	No
Past surgical procedures			Ongoing medical problems		
Have you ever been hospitalized			Seizures		
Have an allergy to food or drugs			Bone/Joint problems		
Wear prescription glasses (must provide)			Doctor order brace/assistive device (must provide)		
Fainting or dizziness while exercising			Skin problems (rashes, acne)		
Asthma (must provide current medication)			Significant medical problems		
Wears Orthodontia (braces)			History of head injury		

If yes to any above questions, please explain:
_____
_____
_____
_____

List current doctor prescribed medications your child is routinely taking: **Please ensure your child has a 30 day supply upon intake**
_____
_____
_____
_____
_____

Who will be responsible for providing while in custody?_____