Medical Treatment/Medication Release Form

Greene County Juvenile Detention Center
Cary Stanley, Detention Director
Shannon Doherty, LPN
2100 Greene Way Blvd., Xenia, OH 45385
(937) 562-4100 Fax (937) 562-4118

1. Should my child, _____ require medical attention during the time he/she is detained in the Greene County Juvenile Detention Center, consent is given for such treatment as deemed necessary by the Greene County Juvenile Detention Center physician, Physicians at Greene Memorial Hospital, affiliates of the medical staff, employees of the hospital, or their designee. I will be responsible for the complete financial coverage and/or payment of such examinations and treatments, including the prescribing of medications.

2. All current prescribed medications for my child will be provided to the Greene County Juvenile Detention Center staff in their original labeled container. I authorize the staff of the Greene County Juvenile Detention Center to assist in the self-administration of such medication in the manner stated on the prescription label. I will be responsible for assuring that my child has a continuing supply of prescribed medications without interruption and accept responsibility of delivery and costs of same.

3. Should my child require non-prescription medication(s) during the time he/she is detained in the Greene County Juvenile Detention Center, I authorize the staff members of the Greene County Juvenile Detention Center to assist in the self-administration of the medications pursuant to physicians order.

4. Should my child require emergency dental care during the time he/she is detained in the Greene County Juvenile Detention Center, consent is given for such examination and treatment authorized by the dentist under contract with the Greene County Juvenile Detention Center. I will be responsible for the complete financial coverage and/or payment of such examinations and treatments, including the prescribing of medications.

5. I hereby authorize the Greene County Juvenile Detention Center staff to assist in the self-administration of Ibuprofen; 200 mg. To 400 mg. (1 to 2 tablets); and Acetaminophen (Tylenol); 325 mg. To 650 mg. (1 to 2 tablets); by mouth every 4 to 6 hours as needed, for headaches, toothaches, fever, minor muscle aches, and menstrual pain. I further understand the risks and benefits of this medication.

6. By signing this form, I agree with the conditions explained above. I also grant permission to any clinic, hospital physician or health agency to release information pertaining to the health or previous medial care of this child to the Greene County Juvenile Detention Center. Said release expires one (1) year from the date of the signature below or written revocation whichever occurs first.

Parent/Legal Guardian:_____ Date:_____ Guarantor D.O.B._____
Street Address:_____ City, State, Zip:_____
Phone (H):_____ (C):_____ (W):_____
Primary Physician:_____ Phone #: _____
Address: _____

PLEASE PROVIDE A COPY OF YOUR CURRENT INSURANCE INFORMATION OR:
Do you have medical insurance? No ___ Yes ___
Company:_____ Policy # _____
Group # _____

Do you have a medical card? No ___ Yes ___ Card # _____