Clear Form

Post-Adjudication
Medical & Medication Authorization Form

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 impatient 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.

If your child is allergic to any food or drugs, please list them below:

Does your child have any medical or psychological problems that the Facility should know about? If so, list them below:

Additional medical information:

Is your child currently medically insured? ☐ Yes ☐ No

If yes, please provide the insurance name: _____, Policy Number: _____

Is your child currently receiving Medicaid? ☐ Yes ☐ No

If yes, please provide the Medicaid Number: _____

Is your child currently receiving services from any of the following? (Check all that apply)

☐ MHMR ☐ Juvenile Alternatives ☐ Counseling

Please provide agency contact information: _____

_____ Parent or Guardian Printed Name

_____ Parent or Guardian Signature

Submit Form