Form D

MEDICAL CONSENT

Last Name of Youth:	First Name of Youth:
County:	Date of Birth:

As a parent/guardian of a youth residing at George Junior Republic in Pennsylvania (GJR in PA), I hereby give medical consent for the following:

☐ **Routine Health Care:** Routine health care includes health examinations, diagnosis, dental care (to include examinations, restoration, and cleaning), vision, hearing, treatment for injuries and illness, and routine immunizations. I understand that treatment for my child's diagnosis may require an x-ray, examination, laboratory, diagnostic, or other types of procedure(s).

☐ **Disclosure of Protected Health Information (PHI):** Following office visits or treatments, health care information is to be disclosed to GJR in PA by health care providers to ensure proper follow up care and compliance.

By signing below, I also acknowledge that:

- My child will not be permitted to be included in any experimental treatment or procedure without further written consent from me, the parent/guardian.
- A separate written consent must be obtained from me (the parent/guardian), or if I (the parent/guardian) cannot be located, by Court Order, for each incident of non-routine treatment such as elective surgery or experimental procedures.
- If a life threatening emergency occurs, my child may be transferred to another medical facility to receive the necessary treatment.

Parent/Guardian Printed Name	***Parent/Guardian Signature***	***Date***

This section is for VERBAL CONSENTS ONLY: Verbal consent requires **TWO** witness signatures.

Witness 1: GJR Representative Printed Name	***Witness 1: GJR Representative Signature***	***Date***
Witness 2: Placing Agency or GJR Representative Printed Name	***Witness 2: Placing Agency or GJR Representative Signature***	***Date***