

La Crosse County
Human Services Department

300 North Fourth Street
P.O. Box 4002
La Crosse, WI 54602-4002

CONSENT FOR MEDICAL TREATMENT

Western Region Adolescent Services

I, _____ as the parent /guardian/custodian
(name)

of _____ hereby authorize the La Crosse County
(name of juvenile)

Western Region Adolescent Services and it's medical/nursing vendor to provide routine and emergency medical and psychiatric care and treatment for the above-named juvenile. I also agree to pay for any medical, pharmaceutical and hospitalization charges that may be accrued for the above named juvenile.

(Signature)

(Date)

Please indicate any exceptions to this consent, including any non-prescription medication your child should not be allowed to take.

Signed and dated form is valid for six months