North Carolina Department of Health and Human Services | Division of Social Services

General Authorization for Treatment and Medication

| **Section A – Identifying Information** | |
|---|---|
| Child's Name: | Date of Birth: |
| Medical Home Provider: | Telephone Number: |
| Other Medical, Dental, or Mental Health Provider or Specialist Prescribing or Administering Treatment: | Telephone Number: |

**Section B – Care, Treatment, and Parental Consent (N.C.G.S. § 7B-505.1)**

When a child is in the custody of the county child welfare agency, the county director may arrange for, provide, or consent to any of the following without obtaining parental consent:

- Routine medical or dental care or treatment (including immunizations in most cases);
- Emergency medical, surgical, psychiatric, psychological, or mental health care or treatment; and,
- Testing and evaluation in exigent circumstances

I hereby authorize _____ county child welfare agency to consent to the following treatment of the child identified above (include description):

☐ Prescriptions for psychotropic medication(s): _____

_____

☐ Participation in a clinical trial: _____

_____

☐ Child Medical Evaluation not otherwise authorized (DSS-5143 Consent/Authorization for Child Medical/Child/Family Evaluation must also be completed): _____

_____

☐ Comprehensive clinical assessment, or other mental health evaluation(s): _____

_____

☐ Surgical, medical, or dental procedure or test that requires informed consent: _____

_____

☐ Psychiatric, psychological, or mental health care or treatment that requires informed consent: _____

_____

☐ Other non-routine or non-emergency treatment or procedure: _____

_____

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Initial all that apply:
___I have been informed of the recommendation that medication be prescribed to my child as part of their treatment plan.
___I have been informed of the recommendation that a surgical, medical, dental, or mental health treatment or procedure be completed on my child as part of their treatment plan.
___I have been notified, of my child's condition;
___If I have questions about my child's treatment, I will contact the health care provider named at the top of this form.
___I have been given a copy of this form.

I understand that I may revoke this authorization at any time. If I do not revoke this authorization it expires automatically as follows:

1. Upon closure of my case; or,
2. One year from the date this authorization is signed; whichever occurs first.

I understand that medication, a medical procedure or mental health treatment is only one aspect of my child's treatment plan and that success and continued improvement depends on my active involvement in treatment planning. Although this medication or procedure is expected to be helpful in the treatment of my child's condition, there is no guarantee that improvement will be seen.

Based on the information provided to me:

☐ I authorize _____ county child welfare agency to consent to the administration of the above mentioned medication, treatment, or procedure.

☐ I refuse to authorize the administration of immunizations due to a religious objection.

## Section C – Appointment and Follow-Up Information

An appointment has been scheduled for _____ at _____. With the
Date Time
following provider: _____ at _____.
Name of Provider/Practice Address/Location

## Section D - Signatures

Parent/Guardian/Custodian signature: _____ Date: _____

Print Name: _____ Relationship: _____

County child welfare staff signature: _____ Date: _____

Print Name: _____ Date: _____

**Written revocation of this consent should be mailed to:**