Authorization to Provide Informed Consent for a Minor

Cowlitz County Juvenile Detention Facility (updated.........July 2021)

This form in not a substitute for the advice of an attorney. Any legal questions you may have about authorizing others to make health care decisions for your minor should be directed to your attorney.

With limited exception, Washington State law requires parents or legal guardians to provide informed consent for health care for their minor child. A minor child is a child under the age of 18 years old for medical care, and under the age of 13 years old for mental health care. In the event a parent or legal guardian is temporarily unavailable to provide informed consent for their minor child, Washington State law permits parents or legal guardians to authorize Cowlitz County Juvenile Detention to provide informed consent for their minor child. By completing this form you authorize Cowlitz County Juvenile Detention to provide informed consent for your minor child in your absence in accordance with the limits specified below.

I am (We are) the parent(s) or legal guardian(s) of the following minor child:

______________________________ _______________________
(Full, legal name of child) (Date of birth)

I (We) authorize Cowlitz County Juvenile Detention to provide informed consent for health care within the limits specified below for the above named minor child.

Cowlitz County Juvenile Detention is authorized to provide informed consent for the following health care at any medical clinic or hospital, anywhere (check all that apply):

_____ Routine health care, not including immunizations
_____ Routine health care, including immunizations
_____ Routine vision care
_____ Emergency health care as deemed necessary by a physician
_____ Any health care deemed necessary by a health care provider
_____ Other (specify):____
_____ Routine mental health care
_____ Routine dental care
_____ Surgical Care

This authorization shall become effective on__________________________ and shall remain in effect for 90 days
(MM/DD/YYYY)
after last contact or __________________________________.
Specify Date

______________________________________ ______________________________________
(Print full name of parent or guardian) (Signature) (Date/Time)

______________________________________ ______________________________________
(Print full name of parent or guardian) (Signature) (Date/Time)
[Both custodial parents must sign if required by court order]

If my child is released from detention and in the event that I (we) am unavailable to retrieve him or her I (we) authorize the Cowlitz County Detention Staff to release my (our) child to one of the following responsible adult(s):

Name [full name, as it appears on their photo ID] *Phone Number*

______________________________________ ________________________________

______________________________________ ________________________________