



HEALTH SERVICES DEPARTMENT- MEDICAL SERVICES PERMIT: DCYF

I, The State of New Hampshire Division for Children, Youth, and Families, as legal guardian of _____, hereby give my authorization to any medical, surgical or dental care, also to include annual physical and bi-annual dental exams which Spaulding Academy & Family Services, on the advice of a licensed Nurse Practitioner, Physician or Dentist, recommends for my student. I understand that I will be consulted concerning any further recommended care prior to it taking place. In addition, I hereby give my authorization for Spaulding Academy & Family Services to engage with any provider for the following medical services for my student on an as needed basis, to include, but not limited to the following:

Allergist, Audiology, Blood Draws, Dental, EEG, EKG, Endocrinology, Gastroenterology, MRI, Neurology, Ophthalmology/Optometry, Orthopedics, Podiatry, Pulmonology, X-ray/scan

Whenever one of the above listed departments/tests are utilized, the test/assessment will be reported via correspondence to DCYF.

In the event of an emergency, I hereby authorize any medical or surgical care* which Spaulding Academy & Family Services, on advice of a licensed Nurse Practitioner, Physician or Dentist, recommends for my student. DCYF must be contacted immediately for consent. I also authorize only localized anesthesia as necessary for emergency medical care until DCYF is contacted. I further understand that Spaulding personnel will contact me at the earliest possible moment to inform me of the emergency.

Authorization:

State of NH DCYF as legal guardian

Date

Witness

Date

*Refer to the DCYF Emergency Guidelines