Shasta County
Health & Human Services Agency

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Foster Parent Authorization for Medical Treatment

Name of Foster Parent: Name of Child:

Address: Child's DOB:

City, state, Zip Code: Date of Placement:

The Foster Parent listed above is hereby given authorization to give consent for medical treatment on the above-named child.

Authorization is valid for duration of placement in this home. Notification is to be given in the event of any change in placement of a child. *Authorization is for treatment consent only.*

For release of records, a release signed by the assigned social worker or another social worker is required.

_____ _____

Signature of Foster Parent Signature of Social Worker

_____ _____

Date Signed Printed Name

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