OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
CONSENT FOR CARE AGREEMENT

I, the undersigned, being the legal guardian of _____,
Printed Name (Patient)

Hereby consent for him/her to be examined and to receive medical care, treatment and case management services as appropriate by physician, or other health care providers as authorized through the Office for Children with Special Health Care Needs (OCSHCN).

_____
Printed Name (Legal Guardian)

_____
Legal Guardian's Relationship to Patient

_____ _____
Signature (Legal Guardian) Date

The Office for Children with Special Health Care Needs does not discriminate against any person based on political belief, race, color, national origin, religion, age, mental or physical disability, or sex.

_____
(*OCSHCN Use Only – CUP ID*)