

## Authorization for Health Care

I, \_\_\_\_\_ of \_\_\_\_\_ County  
Department of Social Services have responsibility for the foster care placement of:

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Medicaid ID #

by virtue of a court order giving the County Department legal custody.

I do hereby authorize \_\_\_\_\_ to consent to:  
Name of Foster parents

- 1) Emergency medical and dental care
- 2) ordinary medical and dental care; and
- 3) to participate in group and individual therapy in accordance with the current family services plan.

The foster home is required to maintain a complete record of all medical and surgical services provided and drugs administered to the above named child.

This authorization shall be in effect during the period of time the child is in the care of the foster parents.

\_\_\_\_\_  
Caseworker Signature

\_\_\_\_\_  
Date

