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.*