Connecticut Department of Children and Families
PERMISSION TO DELIVER OR OBTAIN ROUTINE HEALTH CARE
DCF-460A
1/19 (Rev.)

TO BE GIVEN TO THE CAREGIVER AT THE TIME OF PLACEMENT				
Child's LAST Name:	Child's FIRST Name:	Child's DOB:	LINK #:	Child's Gender: Select One or enter your own
Name of Medical Insurance Provider:	Group #:	Policy #:	Child's Legal Status: Please Select One	
Placement Contact LAST Name:	Placement Contact FIRST Name:	Placement Contact E-mail:	Placement Contact Phone #:	
Placement Address (No. and Street):	City:	State:	Zip:	
SW LAST Name:	SW FIRST Name:	SW E-mail:	SW Phone #:	
SWS LAST Name:	SWS FIRST Name:	SWS E-mail:	SWS Phone #:	
DCF Office of SW: Select DCF Office				

On behalf of the above named child, permission is given to deliver or obtain routine health care as follows:

- EPSDT services, which are age-approporiate periodic screenings and, when indicated, diagnosis and treatment, including comprehensive history and physical examination, appropriate immunizations, laboratory tests, health education and anticipatory guidance, and vision, hearing and dental services;
- Follow-up and monitoring of chronic medical conditions
- Treatment of common childhood diseases;
- Completion of camp physicals and forms; and
- Completion of school forms
- Mental Health Screening and Care (excluding psychotropic medications)

THE UNDERSIGNED, HAVING THE AUTHORITY TO CONSENT ON BEHALF OF THE MINOR NAMED ABOVE, AND HAVING REVIEWED THE EXPLANATION GIVEN BY THE QUALIFIED HEALTH CARE PROVIDER, HEREBY CONSENT TO SUCH PROCEDURE(S) OR TREATMENT(S).

This form expires when a child changes placement or 365 days after the date approved by the Program Supervisor

Parent's Name (if child /youth under and OTC):	Parent's Signature:	Date:
DCF Program Supervisor (or above) name:	DCF Program Supervisor (or above) Title:	
DCF Program Supervisor (or above) Signature:		Date:
DCF Office of Program Supervisor (Only if different from above): Select DCF Office		