CFS 431
Rev 5/2005

State of Illinois
Department of Children and Family Services

CONSENT OF GUARDIAN TO MEDICAL/SURGICAL TREATMENT

As the legal custodian/guardian for the individual minor, _____,
whose birth date is _____, I am authorized to act, pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, on behalf of the minor in making health care related decisions, and I hereby consent to and authorize the following:

- ☐ medical care
- ☐ dental care
- ☐ hospital admission/care
  - ☐ outpatient
  - ☐ inpatient
- ☐ surgical care
- ☐ administration of anesthetics
  - ☐ local
  - ☐ general
  - ☐ conscious sedation
- ☐ administration of blood

as may be required with regard to the following procedure or condition _____

_____

It is understood that these medical and/or surgical or treatment procedures are recommended by Dr._____, (see attached Physician's Statement on page 2 of this consent), whose address is _____, and that these procedures will take place on or about _____, _____, at

_____
(hospital, clinic, or office and address, and phone)

THE ABOVE CONSENT IS SUBJECT TO THE FOLLOWING SPECIAL CONDITIONS:

_____

_____

I retain the right to revoke this consent with written notice to the above-named provider prior to the expiration date. This consent is valid until the minor is released from the specified treatment and/or procedure, or until ___/___/___.

Date: _____

_____
DCFS Guardianship Administrator

Witness: _____

by _____
Authorized Agent

Address: _____

_____

cc:_____
(Service Office)

Telephone:_____
(8:30 a.m.-5:00 p.m.)

_____
(Evenings, Weekends, Holidays)

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PHYSICIAN'S STATEMENT CONCERNING RECOMMENDED MEDICAL/SURGICAL PROCEDURE

Patient's Name:_____ Date of Birth:_____

I. Recommended Elective Procedure (description and correct terminology):

_____

_____

_____

_____

Name and Address of Hospital or Clinic (where procedure will be performed):

_____

_____

Date Scheduled _____

II. Diagnosis and Description of Current Problem: _____

_____

_____

_____

_____

III. Statement of Patient's General Health (include major illnesses in the past, surgical procedures, chronic illnesses, bleeding problems, allergies, chronic administration of medication, any condition which might influence surgical risk or recovery, etc):_____

_____

_____

_____

_____

_____

Name of Physician:_____ Date:_____

Address:_____ Phone No. _____

_____