TN Department of Children's Services

Release from Medical Responsibility

Name of Youth: _____ TFACTS person ID#: _____ DOB: _____

Placement: _____

This is to certify that I, _____, am refusing the following treatment:

I refuse this treatment against the advice of the attending health care provider and his/her assistants. I acknowledge that I have been informed of the risks involved and hereby release the State of Tennessee, Department of Children's Services, and their employees from all responsibility for any ill effects which may result from my refusal. I may withdraw this refusal at any time without fear of reprisal.

_____ _____

Youth Signature ***Date***

_____ _____

Witness Signature ***Date***

Instructions for use of form

1. Fill in name of the child/youth, date of birth, TFACTS person ID number, and current placement.
2. Fill in the child/youth's name after the phrase "This is to certify that I, _____."
3. In the next blank area, fill in the medication, treatment or procedure the child/youth is refusing.
4. Have the youth sign and date the form.
5. Have a witness sign and date the form.
6. If the child/youth refuses to sign, write that on the Youth Signature line and have a witness sign and date the form.
7. If the child/youth refuses a prescribed medication for more than 48 hours, the prescribing provider must be notified for further instruction. It can be dangerous for some medications to be stopped abruptly. If you are unsure, call the prescribing provider immediately. (see policy 20.15 Medication Administration, Storage and Disposal).