Tennessee Department of Children's Services

Release from Medical Responsibility

Name of Youth_____ 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

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Student Medical Record, Youth Regional Case Record (Except for YDC youth)