McLAREN FLINT
PARTIAL HOSPITALIZATION PROGRAM

OUTPATIENT ADOLESCENT PSYCHIATRIC PROGRAM CONSENTS

I, _____, the parent/legal guardian of _____
(parent/legal guardian name) (patient name)
consent to the following regarding my adolescent's treatment at McLaren Regional Medical Center Day Treatment Program:

_____ For my adolescent and his/her belongings to be physically assessed at the time of admission to the program, and when clinically indicated to determine the possession of any non-allowable items which may jeopardize safety and health.

_____ For my adolescent to participate in Pet Therapy and handle/have contact with domestic animals.

_____ For my adolescent to participate in Reproductive Health Education classes.

This form has been fully explained to me and I am satisfied that I understand its content and significance. I understand that if I have any concerns regarding this consent throughout my adolescent's program admission, I will discuss my concern with my adolescent's physician and **that I can** withdraw my consent, **in writing**, if I so desire.

_____ _____
(Date) (Parent/Legal Guardian Signature)

_____ _____
(Date) (Witness Signature)

Person/persons designated to pick your adolescent up:

(Name)	(Relationship)	(Phone)
(Name)	(Relationship)	(Phone)
(Name)	(Relationship)	(Phone)

PT.

MR.#/RM.

DR.