

Superior Court of California
County of Ventura
Family Court Services

PO BOX 6489
800 SOUTH VICTORIA AVENUE
ROOM 307
VENTURA CA 93009

(805) 289-8735
FAX (805) 477-5865

RELEASE OF MEDICAL INFORMATION

I _____, legal guardian of _____
Guardian's Name Child's Name

grant permission for _____
Doctor and Clinic Name

Clinic Address Clinic Telephone Number

to release information about the health and well-being of the ward to the Ventura County Superior Court.

Date Guardian's Signature

Guardian's Printed Name

THE SECTION BELOW WILL BE COMPLETED BY THE HEALTH CARE REPRESENTATIVE

MEDICAL INFORMATION

Case Number: _____ Medical Number: _____

Child's Name: _____ Date of Birth: _____

Guardian: _____

When was your last appointment with the child?

How often have you seen the child in the past year?

Does the child have any conditions which require regular treatment?

Is the child current on the recommended vaccinations? _____

If not, which are overdue? _____

MEDICAL INFORMATION

How would you rate the child's general health? _____

Does the child have any special needs? _____

Does the child have any special problems? _____

Do you have any observations or additional comments regarding the caretaker's (parent, grandparent, or relative) history of responsiveness to the medical needs of the child(ren)? _____

Additional Remarks: _____

Name of person filling out form

Title of person filling out form

Signature of person filling out form

Date of signature