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 oftern 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