General Consent Form

I, _____, certify that I am the _____, of
(Full name of the legally responsible person), (Relationship to the member)

_____.
(Full name of the member)

I consent to the following on their behalf:

Yes	No	
		Necessary emergency treatments: (Consent required)
		Under recorded video surveillance in common areas at all CNS Center Locations (Facility requirement)
		Transportation by Caring Nourishment and Support staff in personal vehicles
		Routine to medical care and/or doctor appointments
		Routine dental care and/or dentist appointments
		Receive PRN medication by CNS staff (PRN form MUST be provided by physician)
		Use of sedation/restraint when prescribed by a physician for medical/dental purposes
		Necessary education, vocational, and therapeutic evaluations/assessments except for:
		Temporary use of CNS wheelchair, adaptive, and/or exercise equipment as needed.
		Participation in routine recreational/leisure activities
		Administration of over-the counter medicines and ongoing medications (prescribed by a physician or dentist and to not exceed the maximum or recommended dosage) except for:
		May be photographed and photos displayed in CNS offices or scrapbooks (photos will not be released to the media or public without specific written permission)

Release of the following information checked "yes".

Yes	No	
		Educational (IEP)
		Social
		Psychological
		Financial
		Other

Caring Nourishment and Support has my consent as the legal guardian to discuss pertinent information regarding the member served, member care, and member services with the following checked "yes".

Yes	No	
		Parents
		Providers
		Medical Personnel
		Therapeutic Personnel
		Other

CARING
Nourishment & Support

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For any categories where I have selected "No," my signature is required before the occurrence of such events or the release of any information.

I understand that I have the right to file a grievance with Caring Nourishment and Support (CNS) or the Division at any time and for any reason related to the delivery of services. This includes, but is not limited to, grievances concerning ineligibility determinations, reductions in services, suspensions or terminations of services, or concerns about the quality of services.

CNS will only provide services for authorized hours and to authorized persons. I acknowledge that CNS's liability insurance does not cover the use of personal equipment or vehicles belonging to families. Any social or recreational fees incurred by the member will remain the responsibility of the member and/or their family.

In the case of a Group Home Placement, the initial placement is subject to a 30-day trial period.

The above terms have been explained to me, and I certify that I fully understand them. I further understand that my consent remains valid until revoked in writing. I may withdraw my consent at any time by providing written notification to the Caring Nourishment and Support administration. I am also aware of my right to seek legal counsel before signing this consent form.

ADH/CDH Provider Signature _____ **Date** _____

Member's signature (If applicable). _____ **Date** _____

Legal Guardian Signature _____ **Date** _____

Caring Nourishment and Support Representative _____ **Date** _____