

# CONSENT TO A MEDICAL EXAMINATION

I, \_\_\_\_\_ do hereby consent  
(CLIENT/RESIDENT, PARENT, DOMESTIC PARTNER, AUTHORIZED REPRESENTATIVE)

to a physical examination of \_\_\_\_\_  
(CLIENT/RESIDENT)

by a physician designated by the State Department of Social Services and also

consent to any laboratory tests associated with the medical examination for the

purpose of investigating the possible abuse or neglect of

\_\_\_\_\_  
(CLIENT/RESIDENT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
(SIGNATURE OF AUTHORIZING PERSON)

\_\_\_\_\_  
(RELATIONSHIP TO CLIENT/RESIDENT—IF OTHER THAN CLIENT/RESIDENT)

\_\_\_\_\_  
(ADDRESS)

\_\_\_\_\_  
(CITY/STATE/ZIP CODE)