CFS 431-1
Rev 4/2017

State of Illinois
Department of Children and Family Services

# CONSENT OF GUARDIAN TO MENTAL HEALTH TREATMENT

As the legal custodian/guardian of _____, a minor whose birth date is _____, I am authorized to act, pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, on behalf of the individual minor in making health care decisions, and I hereby consent to mental health treatment (excluding inpatient psychiatric hospitalizations and psychotropic medications) for the individual minor.

- ☐ Therapy
- ☐ Psychological Assessment
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Counseling
- ☐ Medication Monitoring
- ☐ EEG's and EKG's
- ☐ Blood Level Check

It is understood that such treatment will take place at

_____
(Name, address and telephone number)

THE ABOVE CONSENT IS VALID UNTIL _____
AND IS SUBJECT TO THE FOLLOWING SPECIAL CONDITIONS: _____

_____

The costs, nature and purpose of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment have been explained to me. I understand that my refusal to consent to any of the above services may result in these consequences: _____

_____

I retain the right to revoke this authorization with written notice to the above-named provider prior to the expiration date. This authorization is valid until the minor is released from the specified treatment and/or procedure, or until ____/____/____.

Date _____ _____
DCFS Guardianship Administrator

Witness _____ By _____
Authorized Agent

Address: _____

_____

cc: _____ Telephone: _____
(Service Office) (8:30 a.m.-5:00 p.m.)

_____
(Evenings, Weekends, Holidays)

**NOTE: THE CONSENT OF MINOR 12 YEARS OF AGE OR OLDER IS ALSO REQUIRED**

SIGNED: _____ DATE: _____
(Signature of person 12 years of age or older)

Distribution: One copy to MH Provider One to Case Record One to Substitute Caregiver One to Minor (if 12 years or older)