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HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services

Chapter Six

Medical Consents

Consent is generally required to release medical and mental health records, provide treatment, and for a number of other situations such as prescribing psychiatric medication and testing for HIV. Giving medical consent is agreeing to and understanding the risks and benefits of the services to be provided. Because of their circumstances – being placed outside the home, possibly moving from one placement to another, having agency staff as well as health care providers involved with their care – children in foster care need special oversight and consideration regarding medical consent. As a result, the law generally requires that consent from the parent or guardian be obtained and documented for key medical activities and conditions.

This chapter covers the issues of consent as related to medical and mental health records, information, and treatment for children in foster care.



Sections in this chapter include:

1. Consent to obtain health records
2. Consent/authorization for routine evaluation and treatment
3. Informed consent for non-routine health care
4. Consent and Early Intervention Program
5. Minors' capacity to consent for specific health services
6. Consent and HIV/AIDS
7. Resources

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Medical Consent

The term “medical consent” in this chapter refers to several kinds of consent:

1. Consent for release of prior health records.
2. Consent/authorization for routine evaluation and treatment.
3. Informed consent for non-routine health care.



Health Care Coordination Activities

Make reasonable efforts to obtain consent from the birth parent or guardian to involve them in the health care needs of their child. Even if the birth parent or guardian signs medical consent forms, it is important to continue engaging them in their child’s ongoing medical/mental health treatment.

All signed consent forms must be placed in the child’s health file with other items on the child’s health history.

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1 Consent to Obtain Health Records

Consent is required to obtain a foster child's health records.¹ The earlier the attempt is made to obtain the child's medical history, the better. Preferably, before placement or within 24 hours of placement, try to obtain the parent's or guardian's signature on the agency's consent for release of information form as part of the overall early engagement of the family.



Health Care Coordination Activities

Health care coordination activities to obtain the child's health records include:

- Diligent efforts to obtain records of any previous medical, mental health, or dental treatment.
- No later than 10 days after placement (emergency or Article 10 court-ordered), or before accepting a child into care (voluntary placement), asking the birth parent or guardian for written consent to release the child's past health records.²
- When consent cannot be obtained from the birth parent/guardian, obtaining the local social services commissioner's consent to release the records or a court order if appropriate.³
- Sending written requests with the appropriate consent to known medical providers who have treated the child for the child's treatment history and records.
- For any preschool child, making diligent efforts to obtain the child's birth record from the hospital where the child was born or from another hospital in possession of the record.

Consent for Family Health History

In addition to the child's health history, efforts should be made to learn the health status of birth family members, as this information will be helpful for the child. It is preferable to obtain documentation from the family member's medical provider to verify any condition reported. The person to whom the record pertains must give written consent for the medical provider to release records to you.

There is no prescribed time frame for requesting consent to obtain the family's health records, nor are family members compelled to consent to release of their records, though the assistance of the court

¹ 18 NYCRR 441.22(e); 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

² 18 NYCRR 441.22(e).

³ Ibid.

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may be requested in serious circumstances. If you have received health information that you believe is credible and important for the child's medical provider to know, this information may be provided with the caveat that you are not able to verify it (*see Appendix A for a sample Health History Interview with Family form to assist in collecting this information*).

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2 Consent/Authorization for Routine Evaluation and Treatment

Consent is required for routine evaluation and treatment of a child in foster care.⁴ This includes consent for initial assessment, follow up and treatment, and ongoing periodic re-evaluation, as well as emergency medical or surgical care in the event that the parent or guardian cannot be located at the time such care becomes necessary. Authorization from the child's birth parent/guardian must be included in the child's health record. If authorization was not obtained from the birth parent/guardian, then consent from the local social services commissioner, authorized agency, or the court must be contained in the record.

The parent/guardian is not authorized to consent to medical care in the following two circumstances:

- When the LDSS has custody and guardianship through a surrender or termination of parental rights (child is freed for adoption), only the local commissioner may provide medical consent. If the child was surrendered directly to a voluntary authorized agency, only that agency may provide medical consent. Consents signed by the parent/guardian are no longer valid.
- A person who is 18 years of age or older, is married, or is the parent of a child may give consent to any medical care.⁵ No one else is authorized to consent for care in this case unless the court has determined that the individual is incapacitated and appointed a guardian or has otherwise intervened to authorize medical care.



Health Care Coordination Activities

Health care coordination activities regarding consent for routine evaluation and treatment include:

- Within 10 days of placement, requesting authorization from the birth parent or guardian for all assessments and treatments that are part of the initial comprehensive evaluation. This includes all routine medical and/or mental health assessments, immunizations, and ongoing routine health care.
- Within 10 days of placement, requesting authorization from the birth parent or guardian for emergency medical or surgical care. Your agency may have a specific form for this type of consent, or it may be included in the consent for routine evaluation and treatment form.

⁴ 18 NYCRR 441.22(d).

⁵ PHL 2504.1.

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- When authorization cannot be obtained from the parent or guardian, obtaining authorization from the local social services commissioner or designee for a child placed pursuant to an emergency protective removal or Article 10 court order.
- ➔ Remember to give a copy of the signed consent form for routine evaluation and treatment to the child's primary care provider and any other providers treating the child. It is recommended that staff document any specific discussions about medical consent in the child's health record.

Consent and Voluntary Placement

When a child is voluntarily placed in care, the caseworker may obtain the birth parent's consent for medical/mental health care at the time the Voluntary Placement Agreement is signed.

When Consent Is Not Available

Medical Emergency

- ➔ In a medical emergency, children in foster care should receive treatment even if a signed consent form is not available.⁶

Absence of written consent should not delay emergency or urgent health care.

Legal Authority

When consent is not available, the worker's actions depend on the legal authority under which the child is placed in foster care.

- When the child is placed as a result of an Article 10 court order or emergency protective removal, and there is no signed consent in the child's health record, seek consent from the local commissioner or designee.⁷
- When the child is placed voluntarily or as a result of an Article 7 (PINS) court order, only the birth parent or guardian can give consent to obtain health records and for routine evaluation and treatment. Neither the local commissioner nor the voluntary agency has authority to consent to medical care, so a court order must be sought.

⁶ PHL 2504.4.

⁷ SSL Article 6, Title 1, 383-b.

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- Children may be placed under Article 3 (JD) with a LDSS or with OCFS:
 - When a child is placed with a LDSS commissioner and the parent/guardian does not consent to routine care, a court order must be sought.
 - When a child is placed with OCFS, OCFS has the authority to consent to routine medical care. Thus, if the child is adjudicated as a juvenile delinquent and placed with OCFS and OCFS then places the child with a voluntary authorized agency, OCFS has the authority to consent to routine medical care in the absence of the parent or guardian.

When a parent/guardian refuses to provide needed consent for treatment of a child, this may lead to an evaluation of whether the case should be referred to Child Protective Services (CPS) as a possible medical neglect case. This may be considered even when the situation is not life threatening but there is risk of serious harm if the child is not treated. Consult with an appropriate medical practitioner about the implications of the child not receiving medical care.

Note: Commissioners may delegate specific staff on an administrative level within the agency or in a contract agency to provide written consent on behalf of the commissioner in appropriate cases. Make sure that you know who has this authority. Be familiar with the policies of your agency/local district regarding medical consent for each child under your care.

Consent and Foster Parents

➔ **Foster parents, including kinship foster parents, are not authorized to give consent.** Instruct foster parents to contact the agency for consent if the consent form is not available (e.g., if a prescription for psychiatric medication changes or surgery is being planned). Agencies should establish protocols for giving health care providers a copy of the original signed consent form for their files. The only exception is when foster parents serve as surrogate parents for children in the Early Intervention Program, described in section 4 of this chapter. Then the foster parent can consent to Early Intervention services.

Communicate to foster parents the following information:

1. As a foster parent, you cannot provide consent for medical or mental health treatment. Keep a copy of the signed consent forms with you.
2. If a signed consent form is not in the health care provider's file, and the child needs routine treatment, the provider should contact the agency for consent.
3. In an emergency, the health care provider or emergency room may treat the child even if consent is missing, but they should seek consent from the agency as soon as possible. Have the agency phone number with you at all times.

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Consent and Relatives

There are different circumstances under which children involved with family court may come to reside with relatives. In these cases, it is recommended that agency staff explain consent and guardianship to the child's health care provider(s).

- The relative may be certified as a kinship foster home for a specific child. The child is in foster care. The relative is not authorized to consent to medical care (see above)
- The relative or another person who is not the parent of the child has a lawful order of custody of the child. The child is not in foster care. The relative cannot consent to medical care unless authorized by court order or designated in writing as a person in parental relationship to the child. The relative does have the right to enroll the child in school and enroll the child in their employer-based health insurance plan.⁸
- The relative or another person who is not the parent of the child has been granted legal guardianship or "permanent guardianship." The child is not in foster care. The relative may give medical consent for the child.⁹

⁸ Family Court Act §657. Effective 11/3/08.

⁹ Family Court Act §661(b). Effective 11/3/08.

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3 Informed Consent for Non-Routine Health Care

Even if consent for routine evaluation and treatment has been obtained, medical providers will generally look for a higher level of consent – known as “informed consent” – for non-routine or elective medical or mental health care not generally provided as part of primary health care. Local districts that have obtained consents from a parent or guardian should evaluate the scope of such consent to determine whether it addresses both routine and non-routine medical care and treatment. For procedures or interventions that are not emergency in nature but call for informed consent, the health care provider should always contact the caseworker or the health care coordination staff at the agency. It is then the agency’s responsibility to facilitate the consent process.

Informed consent is required for:

- Any hospitalization.
- Dispensing of any psychiatric medication (*see Chapter 5, Medication Administration and Management*).
- Any procedure that requires anesthesia.
- Any surgery.
- Any invasive diagnostic procedure or treatment.

“Informed consent” implies that the person giving consent has had the opportunity to ask questions, understands the risks, benefits, and alternatives of the treatment, and has been informed of the following types of information:

- Diagnosis and symptoms being treated.
- How the procedure/therapy fits with the treatment plan.
- Nature of the procedure/treatment.
- Benefits, risks, and side effects.
- Projected course and duration of therapy.
- Alternative approaches to treatment.
- Assurance of monitoring for complications and side effects.
- How to contact the clinical provider of the proposed procedure/treatment.
- Location where the procedure/treatment will be performed.
- Necessity, type, and risks of anesthesia, if any.
- Proposed length of hospitalization, if any.

It is best to give this type of information to the person who will provide consent orally (in their native language) and to be available to answer questions. If requested, follow up the discussion with information in writing. If the informed consent is for psychiatric medication, written information on the medication should always be provided.

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Authority to Provide Informed Consent

As with consent for routine care, the authority to provide informed consent is dependent upon the legal authority under which the child was placed in foster care. The parent/guardian should be asked to provide informed consent unless parental rights have been surrendered or terminated, or the child is 18 or older, married, or the parent of a child.

If the birth parent or guardian objects to signing the consent, take the following steps:

- Work with them to understand the basis of the objection.
- Pursue any reasonable treatment options that the parent may suggest.
- Provide the parent or guardian an opportunity to meet with the practitioner and treatment team.
- Assist the parent or guardian in obtaining a second opinion, if requested.

If Parent/Guardian Does Not Give Consent for Psychiatric Medication¹⁰

If the parent or guardian and the treatment team cannot agree on the use of psychiatric medication, the local district or authorized agency may wish to seek legal counsel to determine if court intervention is advisable.

If the parent or guardian is *unavailable* or the parent or guardian *does not respond* to repeated requests to provide informed consent, consent may be provided in accordance with the legal placement authority.

- If the child is placed pursuant to an order or adjudication under Article 10 (child protective) of the Family Court Act (FCA), the social services commissioner or his or her designee can provide consent.
- If the child is placed voluntarily or pursuant to FCA Article 7 (PINS), a court order must be sought to authorize the medication.
- If a youth is placed pursuant to FCA Article 3 (juvenile delinquent) in the custody of a local social services district, a court order must be sought to authorize the medication.
- If the youth is placed pursuant to FCA Article 3 in the custody of OCFS and psychiatric medications were part of an existing health care plan at the time the youth was admitted to OCFS custody, the placement order authorizes OCFS to continue the existing course of treatment without additional consent. The introduction of new psychiatric medications would require a court order.

¹⁰ For more information, see: 08-OCFS-INF-02 The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care. http://ocfs.state.nyenet/policies/external/ocfs_2008/infs/08

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- If a child is placed pursuant to a surrender or termination of parental rights, the social services commissioner or authorized agency with guardianship of the child provides consent. Parental consent is not sought.

The commissioner or designee and the court if applicable must also receive information on the medication in order to provide an informed consent (*see Appendix A for sample forms*).

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4 Consent and Early Intervention Program

The Early Intervention (EI) Program requires the appointment of a “surrogate parent” to assume the responsibilities of a birth parent/guardian when a child in foster care is eligible for Early Intervention Services and is either a ward of the state – i.e., in the custody and guardianship of the local commissioner of social services – or is not a ward of the state but whose birth parent/guardian is unavailable. The Early Intervention Official/Designee (EIO/D) should designate the foster parent or an appropriate and available relative as the surrogate parent for the EI Program (*see Appendix D for the Protocol: Children in Foster Care Who Participate in the Early Intervention Program, pages 10-12, for information on appointing a surrogate parent*).

The role of the surrogate parent is to make decisions regarding the child within the Early Intervention system. The surrogate parent is afforded the same rights and responsibilities as afforded to the parent and represents the child in all matters related to: screening, evaluation, Individualized Family Service Plan (IFSP) development and implementation, provision of early intervention services, periodic review of IFSP services, and due process procedures. A surrogate parent has access to all Early Intervention Program records concerning the child and due process rights related to those records.

When a child is in foster care and a referral has been made to the EI Program, the EIO/D should consult with the social services district to determine whether parental rights have been terminated or voluntarily surrendered, and whether the parent is available. This also provides an opportunity to share information; identify any potential barrier to parental consent and participation; and determine the need for and identify, as appropriate, a suitable surrogate parent.

A surrogate parent and a birth parent/guardian are not mutually exclusive, and a child can have both. Unless parental rights have been terminated, the EI Program and foster care systems should take steps to encourage the birth parent/guardian to be involved in the IFSP process and in Early Intervention services even when a surrogate parent has been appointed.

Under the Individuals with Disabilities Education Act (IDEA), the surrogate parent may *not* be an employee of any state agency (LDSS commissioner, caseworker, case manager, case planner) or a person or employee of a person providing Early Intervention services (EIO/D, EI Service Coordinator) to the child. The IDEA specifically excludes state officials from acting as a surrogate parent in the EI Program.

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5 Minors' Capacity to Consent for Specific Health Services

Minors (persons under the age of 18) may give consent to obtain past health records and to receive specific health services if it has been determined that they have the “capacity to consent.” Capacity to consent means “an individual’s ability, determined without regard to the individual’s age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure; or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision about the service, treatment, procedure, or disclosure.”¹¹ Capacity to consent is defined by the health care practitioner who is providing the treatment.

This means that a minor with capacity to consent can make choices regarding testing and treatment for the health services listed below without consulting a parent or other responsible adult. Although a minor with capacity to consent may consent for the specific health services listed below, health care providers and agency staff may wish to encourage the youth to talk over the situation with a parent or supportive adult. Even a minor who understands the risks and benefits and can make the decision alone may benefit from support and discussion with a trusted adult.

Reproductive Health Services/Family Planning Services

Minors may give consent to receive reproductive health services and family planning services.¹² This includes gynecological exams, pap tests, contraceptives (including emergency contraceptives), pregnancy testing, pregnancy options counseling, counseling on sexual decision-making, and treatment for vaginal infections. Pregnant teens may give consent to medical, dental, health, and hospital services related to prenatal care.

Minors may consent to their own testing and treatment for sexually transmitted diseases (STDs).¹³

Minors may consent to their own pregnancy termination.¹⁴ The youth has no obligation to report the pregnancy or the termination to the agency, birth parent/guardian, or foster parent.

¹¹ PHL Article 27-F; 18 NYCRR 441.22(b)(1).

¹² 431 U.S. 678; 1977 U.S. Supreme Court decision in *Carey vs. Population Services International*.

¹³ PHL Article 23, 2305(2).

¹⁴ PHL Article 25, 2504.

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Consent and Teen Parents

- Any person who is the parent of a child may give effective consent for medical, dental, health, and hospital services for herself or himself, and the consent of no other person is necessary.¹⁵
- If a teen parent is in foster care and has custody of her child who is not in foster care, the teen may give consent for health care for herself and her child.¹⁶
- If the teen parent and her child are both in foster care together, the teen may give consent for health care for herself and her child.
- If the teen parent and her child are both in foster care, but the child lives elsewhere because of an Article 10 removal, the local social services commissioner can give consent if the teen parent refuses.

It is recommended that staff explain these situations and related consent issues with health care providers.

Outpatient Mental Health Services

Mental health services are considered part of routine health care, and consent is provided pursuant to the parent/guardian's authorization obtained when the child enters care. Parental consent is required, except as noted below.¹⁷

Minors may consent to outpatient mental health services if the youth knowingly and voluntarily seeks the services, the services are deemed necessary to the youth's well-being, and (1) the parent/guardian has refused consent; (2) the parent/guardian is not reasonably available to consent; or (3) requiring consent of the parent could have a detrimental effect on the treatment.¹⁸

Inpatient Psychiatric Services

Youth 16 or older residing in a hospital may consent to medically necessary psychiatric medications if (1) the parent/guardian is not reasonably available to consent; (2) the parent/guardian refuses consent (and a second medical opinion confirms the capacity of the youth to consent and necessity of medication); or (3) requiring consent of the parent could have a detrimental effect on the minor (and a second medical opinion confirms possible detrimental effect, capacity of the youth to consent, and necessity of medications).¹⁹

¹⁵ PHL 2504.1.

¹⁶ PHL 2504.

¹⁷ MHL 33.21.

¹⁸ Ibid.

¹⁹ Ibid.

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A patient who is a minor may be provided treatment over his or her objection if the patient's parent, legal guardian, or other legally authorized representative has consented to the treatment, and the treatment is not one for which the consent of a minor would be legally sufficient. An independent review process is required if the minor is a patient in a State-operated psychiatric center and objects to psychiatric medication.²⁰

In regard to the right to object, a patient under the age of 18 in a hospital or secure treatment facility operated by the Office of Mental Health is considered an adult rather than a minor if that person is married, the parent of a child, or has made a voluntary application for admission.²¹

Chemical Dependency Services

Chemical dependency services are considered part of routine health care, and consent is provided pursuant to the parent/guardian's authorization obtained when the child enters care. Parental consent is required, except as noted below.²²

Minors may consent to alcohol abuse and substance abuse services if treatment is deemed necessary for the child's best interests, and (1) the parent/guardian has refused consent; (2) the parent/guardian is not reasonably available; or (3) requiring consent of the parent could have a detrimental effect on the course of treatment.²³ This includes alcohol abuse and substance abuse services provided on an inpatient, residential, or outpatient treatment basis.

Admission to chemical dependence residential rehabilitation services for youth is voluntary. A patient is free to discharge himself or herself from the service provider at any time.²⁴

Blood Donations

Any person age 17 or over can consent to donate blood in any voluntary and noncompensatory blood program.²⁵

²⁰ 14 NYCRR 527.8(c)(2).

²¹ 14 NYCRR 527.8(a)(5).

²² MHL 22.11.

²³ MHL 22.11.

²⁴ 14 NYCRR 817.3(k).

²⁵ PHL Article 31, 3123.

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6 Consent and HIV/AIDS²⁶

Considering the extent of the HIV/AIDS epidemic and the lack of vaccine or cure for the disease, agencies must take preventive measures including risk assessment, counseling, and testing, and arrange for medical care when needed. As noted in Chapter 1, Initial Evaluation of Child's Health, all children entering foster care must be assessed for risk of HIV. Who can give consent for HIV risk assessment and testing and how consent is obtained are important issues. The agency must have protocols as to who is the local commissioner's designee in this matter and a consent document that addresses HIV to present to the health care provider. General consent forms do not address consent for an HIV test. (See Chapter 7, Confidentiality of Health Information, for information on HIV testing and confidentiality).

It is recommended that designated staff who are informed about HIV, foster care, and developmental stages make the determination as to whether a child has the capacity to consent. Designated staff may include health staff, social work staff, and medical providers.

Children in foster care may consent for HIV testing and family planning procedures if it has been determined that they have the capacity to consent. → **No one other than the child can consent to an HIV test if the child has the capacity to consent.**

Initial HIV Risk Assessment

Regarding the initial HIV risk assessment, first determine which alternative applies: (1) there is no possibility that the child has the capacity to consent; or (2) there may be a possibility that the child has the capacity to consent.

The following categories provide best practice guidelines for making the determination:

- Infants and preschool children clearly have no capacity to consent. Obtain consent from the parent or legal guardian, the designated representative on an administrative level, or by court order, and complete the initial risk assessment within five days of placement.
- Elementary school children generally will have no possibility of capacity to consent, particularly in the lower grades. Since there may be a possibility of such capacity in exceptional cases, complete the risk assessment and determine capacity to consent for HIV testing within 30 days of placement.

²⁶ 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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- Middle school children are more likely to have the possibility of capacity to consent, but the broad range in individual development requires a case-by-case determination. It is recommended that a supervisor review the determination. Since there may be a possibility of such capacity, complete the risk assessment and determine capacity to consent for HIV testing within 30 days of placement.
- High school and post-high school youth will generally have the capacity to consent, although there may be exceptions in cases of developmental delay or disability and/or mental or emotional instability. In most cases, adolescents and young adults will be able to understand and appreciate the nature and consequences of the disease and make an informed decision regarding the recommended testing when risk is identified. Complete the risk assessment and determine capacity to consent for HIV testing within 30 days of placement.

HIV Testing

When HIV risk has been identified, designated staff will need to obtain legal written consent before the child can be tested. The current DOH consent form should be used (*see section 7, Resources*). Caseworkers may never provide legal consent for HIV testing of a foster child. Inform foster parents and prospective adoptive parents that they may never provide legal consent for HIV testing of a foster child.

If a child or youth has been determined to have the capacity to consent, and agrees to be tested (after being identified as having one or more risk factors and counseled regarding testing and confidentiality), obtain his or her signature on a brief statement of consent.²⁷ A child with capacity to consent is the only person who can make the decision about testing and consent to the test. The child will also have to sign a consent form at the test site.

If it has been determined that a child does *not* have the capacity to consent, staff follow a different process depending on how the child was placed in foster care:

- For a child placed by emergency protective removal or by an Article 10 court order, ask the parent/guardian for permission to test the child for HIV and request a written response within 10 days. If the parent agrees to give consent for the test in writing and is able to be present at the test site with the child, schedule the appointment and make arrangements for the test, including transportation, if necessary. If the parent refuses or is unable to provide written permission for testing a child identified as being at risk, and you have made reasonable efforts to contact him or her and discuss the importance of the test, you will need to obtain the legal consent for testing from the local commissioner or designee.

²⁷ This consent form is for the LDSS. At the testing site, the youth will be asked to sign the Department of Health's official informed consent form.

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- For a child placed voluntarily by the parent/guardian, or placed as a PINS or JD, written consent from the birth parent or guardian is required in order to test the child for HIV. If the parent/guardian refuses to provide consent, discuss the importance of early detection. If the parent continues to refuse, determine whether to ask for a court order based on urgent medical necessity.
- For children under 12 months of age at entry into care, request results of the Newborn Screening within 10 days of entry into care. Under New York State law, a sample of blood is taken from every newborn to test for several serious disorders. Since 1997, the Newborn Screening Program has included an HIV test. If the test is positive, that means the child has been exposed to the HIV virus. Seek medical care immediately. *(See Chapter 3, Special Health Care Services, section 2, HIV-Related Services, Newborn Screening Program.)*



Health Care Coordination Activities

Whenever the local social services commissioner or designee is responsible for providing consent for HIV testing, health care coordination activities include obtaining the signed consent and making arrangements for the test.

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7 Resources

New York Civil Liberties Union

Go to <http://www.nyclu.org/>, select Resources – Know Your Rights. Information on reproductive rights is available.

HIV Consent

See Appendix A for the “Informed Consent to Perform an HIV Test” form (DOH-2556). For a copy of the form in English and other languages, go to the NYS Department of Health website, <http://www.health.state.ny.us/>, and click on HIV/AIDS.

See Appendix B for 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure. This ADM includes model forms for HIV consent.

Brochures on Consent

- *Medical Consent for Foster Children*
- *Consent for Psychotropic Medication*

Both brochures are available from the Office of Medical Services Planning, New York City Administration for Children’s Services (ACS), 150 William St., 14th Floor, New York, NY 10038.

- *Pediatric AIDS Unit (for consent related to HIV/AIDS)*

This brochure is available from the Pediatric AIDS Unit, New York City Administration for Children’s Services (ACS), 150 William St., 14-P1, New York, NY 10038.