

BROWN COUNTY PROBATION DEPARTMENT

MEDICAL INFORMATION AND AGREEMENT

I, _____ hereby inform the Probation Department that I:
(juvenile's name)

- do do not have a disability or medical problem which would prevent me from participating on the work crew
- am am not under a doctor's orders regarding work
- do do not have an allergies

IF YOU HAVE ANY DISABILITIES OR MEDICAL PROBLEMS, COMPLETE THE FOLLOWING:

(1) Medical condition: Specify _____

(2) Parents Insurance Co. _____

Policy Number _____

(3) Clinic and Physician Info. _____

I understand that if I am injured while performing work service I **must** notify my work service supervisor **immediately**. I also understand that my medical insurance must be used to pay for medical costs. For individuals ordered to work service by the District Court Judge and do not have any medical insurance, I must contact my community work service coordinator/agent within 24 hours of the date of the injury to file a claim otherwise I will assume full responsibility for my medical costs.

I declare under penalties of perjury that I have examined this document and that it is true, correct and complete to the best of my knowledge and belief.

EMERGENCY CONTACT : **PARENTS:** Please complete this section, listing a phone number which is available during both the **day and evening**.

Juvenile's Signature

Parent/Guardian Name Signature

Relationship

Day Number / Evening Number