Mississippi Department of Human Services
Division of Youth Services
Medical Services

Name:_____ **DOB:**_____

Date: **Time:**

Check Item/s Refused:

□ **Medication** _____
Medication Name Dose Time

□ **Medical Treatment** _____
Name of Treatment Refused

□ **Medical Assessment**_____
Type of Service Refused (i.e. pelvic exam, Gynecological)

□ **Dental Treatment** _____
Type of Service Refused (i.e. exam, root canal, ALL)

I, _____, am refusing the above checked items.

I understand that by refusing the above services, treatments, medications I may continue to have Pain, Discomfort, Infection, Behavioral Difficulties, sleep difficulties and/or sleep deprivation.

_____
Signature

_____
Witness (JCO or Security)

_____
Nurse Signature