Local DHS office: _____

Consent to Travel

DHS | Oregon Department of Human Services
CHILD WELFARE
Office of Child Welfare Programs

Permission is here by granted for

_____ _____ _____/_____
(Child's name) (Date of birth) (Case number/participant number)

to accompany: _____ while in voluntary or court
(foster parents, staff, etc.)

ordered care and custody of the Department of Human Services (DHS), to the following destination:

_____

for the purpose of: _____

Caseworker name: _____ Phone number: _____

Period of time

Date of departure: _____ Date of return: _____

Emergency care

In the event of an emergency: _____ Phone number: _____
has my permission to authorize emergency care or treatment during the above period of time if I am not available.

Special medical needs/problems:

- ☐ Allergies
- ☐ Heart
- ☐ Diabetes
- ☐ Insect bites
- ☐ Drug reaction
- ☐ Epilepsy
- ☐ Other: *(specify)* _____

If any of the above items are checked, please explain: _____

_____

Name of family physician: _____ Phone number: _____

Address: _____

Name of medical insurance company: _____

Address: _____

- ☐ The child(s) parent(s) have been contacted and agree with the plan.
- ☐ The child(s) parent(s) do not agree with the plan.
- ☐ The child(s) parent(s) are not available.

Signatures

Parent/guardian: _____ Date: _____

Local DHS office supervisor: _____ Date: _____

CW program manager: _____ Date: _____

District manager: _____ Date: _____

CW deputy director/designee: _____ Date: _____

Payment for emergency medical care can be made within the territorial limits of the U. S. If such a need arises, the above authorized person is to present the child's medical care ID to the medical vendor with instruction to call the responsible managed care plan *(if the child is enrolled with a plan)* or for children with an "open card," call DHS, Department of Medical Assistance Program (DMAP), Out-of-State claims at 1-800-336-6016. The billing address for these medical claims is: DMAP, OOS Claims, PO Box 14016, Salem, OR 97309. The medical provider must agree to enroll with DMAP to receive payment. Provider enrollment can be reached at 1-800-336-6016 or provider.enrollment@state.or.us.