

Pat Quinn
Governor



Richard H. Calica
Director

Illinois Department of Children & Family Services

REQUEST FOR COPY OF CONSENT

All requests for copies of consents must **FIRST** be made to the child's caseworker/supervisor. If the copy is not received in a timely manner, please complete this request form and fax to the Consent Unit at (312) 814-4128.

DATE OF REQUEST: _____

CHILD'S NAME: _____

DATE OF BIRTH: _____

DCFS I.D. #: _____

Caseworker Name & Phone Number _____

Date request made to child's caseworker/supervisor _____

CHECK APPROPRIATE BOX FOR TYPE OF CONSENT REQUEST:

- PSYCHOTROPIC MEDICATION**

DATE MEDICATION WAS APPROVED _____

LIST MEDICATION (S) _____

- MEDICAL**

DATE PROCEDURE APPROVED _____

PROCEDURE/MEDICATION _____

REQUESTOR'S NAME, TITLE & PHONE NUMBER: _____

REQUESTOR'S FAX NUMBER: _____

REQUESTS WILL BE PROCESSED WITHIN 5 WORKING/7 BUSINESS DAYS.

Division of Guardian and Advocacy
Consent Unit

17 North State Street, 7th Floor • Chicago, Illinois 60602

800-828-2179 Hotline • 312-814-4128 Fax



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