PHYSICIAN'S *(Name and address):*	*FOR COURT USE ONLY*
TELEPHONE NO.: E-MAIL ADDRESS *(Optional):*	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO STREET ADDRESS: 3341 Power Inn Road, MAILING ADDRESS: William R. Ridgeway Family Relations Courthouse CITY AND ZIP CODE: Sacramento, CA 95826 BRANCH NAME: Sitting as the Juvenile Court	
CHILD(REN)'S NAMES:	CASE NUMBER(S):
PHYSICIAN'S DECLARATION **RE: MEDICAL, SURGICAL, OR DENTAL CARE (WIC Code § 369)**	DEPARTMENT:
THE REQUEST IS AN: ☐ EMERGENCY ☐ NON-EMERGENCY	

This declaration and any attachments must be typed and completed with as much detailed information as possible. You may attach any clinical information which clarifies the treatment plan. In lieu of a form Declaration, a typed letter may be submitted provided it contains all of the information requested in this form Declaration. The signed Declaration or letter should be submitted to the Department of Child, Family and Adult Services social worker assigned to the child's case.

A. The child has been diagnosed with the following condition(s):

B. It is the undersigned physician's recommendation that the child be provided the following emergency or non-routine medical, surgical, or dental care:

1. The purpose of the emergency or non-routine medical, surgical, or dental care is as follows:

2. The probable degree and duration of any risks of the medical intervention is as follows:

3. The probable degree and duration of any benefit(s) of the medical intervention is as follows:

4. The consequences of not having the emergency or non-routine medical, surgical, or dental cares is the following:

5. The reasonable alternatives to the emergency or non-routine medical, surgical, or dental care, if any, and their risks and benefits are the following:

6. If hospitalization is necessary, it is estimated the child will be hospitalized for what duration:

7. Is ongoing medical/dental treatment necessary? If so, what is needed?

8. Any other information you would like to provide the Court:

C. Signature of Physician

I declare under penalty of perjury under the laws of the State of California that the information in this form is true and correct to my knowledge.

Date	Type Name	► Signature

*Telephone No: _____ or other: _____

*Please list telephone number(s) where physician can be reached personally and quickly, 24 hours a day.