**Psychotropic medication treatment consent**

**CPS – Medical services**

**Purpose:** The person legally authorized to consent to medical care on behalf of a child in DFPS conservatorship uses this form to document informed consent for a new psychotropic medication. This form does not replace or substitute for any consent form required or used by a medical provider for their records or purposes.

**Directions:** After completing this form, the medical consenter provides a copy of the form to the DFPS caseworker for the child. The caseworker files it under the child’s section in the case record.

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| I am providing consent for |   |
|  | Child’s name |

|  |  |
| --- | --- |
| To receive treatment for |       |
|  | Condition being treated |

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| --- |
| With the following Psychotropic Medication: |
|       |
| * I received information describing:
 |

(A)  the specific condition to be treated;

(B)  the beneficial effects on that condition expected from the medication;

(C)  the probable health and mental health consequences of not consenting to the medication;

(D)  the probable clinically significant side effects and risks associated with the medication; and

(E)  the generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reasons for the proposed course of treatment.

* I have been given the opportunity to ask questions.
* This consent is given voluntarily and without undue influence.
* I am the child's Medical Consenter.
* I understand that I have the right to choose not to consent to the initiation of this medication. If I choose not to consent to medication recommended by the medical professional, I must notify the child’s caseworker within 24 hours.
* I understand that I have the right to withdraw consent for this treatment at any time, after consulting with the prescribing provider and the child’s caseworker.

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| --- | --- | --- |
|       | Date |       |
| Medical Consenter (print name) |  |  |
|  | Date |       |
| Medical Consenter (signature) |  |  |
|  | Date |       |
| Acknowledged by Prescribing Provider or Designee (signature) |  |  |