



CONSENT FOR TREATMENT WITH PSYCHOTROPIC MEDICATION

Purpose: Use this form to keep a record of informed consent for a psychotropic medication that is prescribed for a child or youth in DFPS care. This form does not replace or substitute for any form that a medical provider requires or uses for his or her purposes.

Directions: To complete this form, the child’s medical consenter fills out all sections except the last section (*Medical Provider’s Signature*). The medical consenter is the person legally authorized to consent to medical care on behalf of a child in DFPS care. The medical provider who is prescribing the medication (or his or her designee) completes the last section. The medical consenter gives a copy of the completed form to the child’s caseworker. The caseworker files it under the child’s section in the case record. If you have questions, please contact the child’s caseworker.

BASIC INFORMATION	
Child’s Name:	DFPS Person ID:
Condition Being Treated:	
Psychotropic Medication Prescribed:	

CONSENT
I am the child’s medical consenter.
I am providing consent for the child named above to receive treatment for the condition named above, using the psychotropic medication named above.
I have received information describing all of the following: <ul style="list-style-type: none"> The specific condition to be treated. What improvements to that condition the medication will probably cause. What will probably happen to the child’s physical and mental health if he or she does not receive the medication. What side effects the medication will probably cause and what risks come with the medication. What other generally-accepted treatments exist (such as other medications or non-medication treatments), if any, and why this medication is recommended.
I have had the opportunity to ask questions.
I am following the DFPS guidelines for medical consenters voluntarily and without being pressured to do so.
I understand that I have the right to choose not to consent to this medication, but if I choose not to consent, I am required to notify the child’s caseworker within 24 hours of making that decision.
I understand that I have the right to withdraw consent for this medication at any time, after consulting with the medical provider who is prescribing it and with the child’s caseworker.



MEDICATIONS PRESCRIBED

Reason for Visit:

Texas Health Steps/Routine Visit Emergency/Urgent/Sick Visit Other

Medication	Dosage	Prescribed For	Instructions	New	Changed	Discontinued
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our [Privacy and Security Policy](#).

MEDICAL CONSENTER'S SIGNATURE

Printed Name of Medical Consenter:

Signature of Medical Consenter:

X

Date Signed:

MEDICAL PROVIDER'S SIGNATURE

I acknowledge that I am the medical provider who is prescribing this medication for this child (or I am the medical provider's designee), and I have had an opportunity to read this completed form.

Printed Name of Medical Provider or Designee:

Signature of Medical Provider or Designee:

X

Date Signed: