



Tennessee Department of Children's Services Informed Consent for Psychotropic Medication

Child's Name: _____ Date: _____

DOB: _____ Social Security Number: _____ Sex: _____ Race: _____

Facility: _____ Home County: _____

Family Service Worker: _____ Adjudication: _____

A COPY OF THE PRESCRIPTION MUST BE ATTACHED TO THIS REQUEST

Medication (dose & frequency): _____

For the treatment of: _____

Allergies: _____ Child entering custody on above listed medication(s)

Any other medication child is taking: _____

Prescribing provider's name and phone number: _____

I have been informed of the recommendation that medication be prescribed as part of my/my child's treatment program. I have been informed of the nature of my/my child's condition, the risks and benefits of treatment with the above medication, of other forms of treatment, as well as the risks of no treatment. My signature below indicates that I have received information explaining the most common side effects of this/these medication(s), but understand that there may be other side effects.

I understand that medication is only one aspect of my/my child's overall treatment, and that success and improvement depends on my active involvement and participation in all aspects of the treatment plan developed for me/my child. I also understand that although this medication is expected to be helpful in the treatment of my/my child's condition, there is no absolute guarantee as to the results.

For females: Because this/these medication(s) could be harmful to a developing fetus, I will notify the medical staff immediately if I suspect pregnancy or have plans to attempt pregnancy.

Based on the information provided to me: (check one)

I give **PERMISSION/CONSENT** to the administration of the above listed medications(s).

I **REFUSE** to allow the administration of the above listed medication(s).

Patient's signature : _____ Date : _____

Parent/legal guardian signature: _____ Date: _____

Print name: _____ Relationship: _____

Reason parent cannot sign: _____

DCS nurse/YDC superintendent: _____ Date: _____

Print name: _____ Region _____

Witness (optional): _____ Date: _____

I have been **NOTIFIED** that consent was given by DCS for the above listed medications(s).

Parent/legal guardian signature: _____ Date: _____

Print name: _____ Relationship: _____

Please disregard all previous versions prior to the date listed below. Always check "Forms" Website for most current version.

Distribution: Child's Case File, Child's Birth Family, Regional Health Nurse, Child's Health Care Provider, Private Provider