AUTHORIZATION FOR PSYCHOTROPIC MEDICATION

State Form 53545 (5-08) / CW 3231
DEPARTMENT OF CHILD SERVICES

In accordance with Department of Child Services (DCS) policy, consent must be obtained from the child's parent/guardian/custodian and from DCS prior to giving any child in out-of-home care psychotropic medication. See the DCS Psychotropic Medication policy for exceptions.

PART A - *To be completed by the physician prescribing the medication*

Name of physician	Physician contact number ( )
Name of child	Child's date of birth (*month, day, year*)
Diagnosis	Date of diagnosis (*month, day, year*)

Was the child given unauthorized medications due to an emergency? ☐ Yes ☐ No

If yes, please explain the situation below and list all medications given to the child, as well all other intervention that was attempted.

Explain

RECOMMENDED MEDICATION	DOSAGE	TARGETED SYMPTOMS	DURATION

Please attach a list of all potential side effects and/or adverse reactions for each medication listed above.

Are there any potentially irreversible side effects? ☐ Yes ☐ No

If yes, please explain in detail.

Will routine blood draws be needed while the child is on this medication? ☐ Yes ☐ No

If yes, please explain in detail below.

Explain

Please explain how the medications listed above will interact with other medications the child takes.

Please explain what alternate treatment options are available.

Please explain what additional treatment will be used, i.e. individual counseling, group therapy, etc.

By signing below, I certify that the above information is true to the best of my knowledge.

Signature of physician	Date (*month, day, year*)

PART B - *To be completed by the child's parent / guardian / custodian (CHECK ONE)*

☐ By signing below, I give my consent for _____ to take the medication(s) listed above as recommended by his/her physician.
Name of child

Signature of parent / guardian / custodian	Date (*month, day, year*)

☐ By signing below, I **do not** give my consent for _____ to take the medication(s) listed above as recommended by his/her physician.
Name of child

Signature of parent / guardian / custodian	Date (*month, day, year*)

PART C - *To be completed by the DCS local director or designee (CHECK ALL THAT APPLY)*

☐ By signing below, I give my consent for _____ to take the medication(s) listed above as recommended by his/her physician.
Name of child

☐ By signing below, I waive **the requirement to obtain consent from the child's parent / guardian / custodian because:**
- ☐ A court order has been issued authorizing the medication;
- ☐ The parent/guardian/custodian cannot be located;
- ☐ Parental rights have been terminated;
- ☐ The parent/guardian/custodian is unable to make a decision due physical or mental incapacitation.

☐ By signing below, I **do not** give my consent for _____ to take the medication(s) listed above as recommended by his/her physician.
Name of child

Signature of local DCS office director		Date (*month, day, year*)
County	DCS region	Contact number ( )