Tennessee Department of Children's Services

Informed Consent for Psychotropic Medication

Appointment Date _____ TFACTS Person ID# _ _____ Home Co. _____

Child's Name _____ DOB _____

Placement ☐ Foster home ☐ Congregate care facility Facility name _____

☐ Child entering custody on the medication(s) listed below

PLEASE ATTACH PSYCHOTROPIC MEDICATION EVALUATION Form CS-0629 OR EQUIVALENT FORM

Medication (dose, frequency, route) _____

_____

For the treatment of _____

Allergies _____

Any other medication child is taking _____

Prescribing Provider's Name _____ Telephone # _____

Clinic Name _____

Address _____

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.

THIS FORM CAN ONLY BE SIGNED BY THE PARENT/GUARDIAN, YOUTH AGE 16 AND OLDER (at the discretion of the prescribing provider**) OR THE DCS REGIONAL Nurse**

Based on the information provided to me:

☐ 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).

Youth age 16 or older signature_____ Date_____

Parent/Legal Guardian signature_____ Date_____

Print name_____ Relationship_____

Witness #1 Verbal Consent_____ Date_____

Witness #2 Verbal Consent_____ Date_____

Reason parent cannot sign_____

DCS Health Nurse Signature _____ Date_____

Print name_____ Region _____

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

Parent/Legal Guardian signature_____ Date_____

Print name_____ Relationship_____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Child's Group Home File