#  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 |
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| Child’s Name:      | DFPS Person ID:      |
| Condition Being Treated:      |
| Psychotropic Medication Prescribed:      |

| CONSENT |
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| 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:* 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.
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| 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   |
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| Reason for Visit:  [ ]  Texas Health Steps/Routine Visit [ ]  Emergency/Urgent/Sick Visit [ ]  Other       |
| Medication | Dosage | Prescribed For | Instructions | New | Changed | Discontinued |
|       |       |       |       | [ ]  | [ ]  | [ ]  |
|       |       |       |       | [ ]  | [ ]  | [ ]  |
|       |       |       |       | [ ]  | [ ]  | [ ]  |
|       |       |       |       | [ ]  | [ ]  | [ ]  |
|       |       |       |       | [ ]  | [ ]  | [ ]  |
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| PRIVACY STATEMENT |
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| DFPS values your privacy. For more information, read our [Privacy and Security Policy](https://www.dfps.state.tx.us/policies/Website/). |

| MEDICAL CONSENTER’S SIGNATURE |
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| Printed Name of Medical Consenter:      |
| Signature of Medical Consenter:X       | Date Signed:      |

| MEDICAL PROVIDER’S SIGNATURE |
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| 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:      |