Consent to Treatment with Medications

Patient's Name: _____ Date: _____/_____/_____

My child's psychiatrist has prescribed the following medication(s) for the treatment of my child's psychiatric and/or behavioral problems:

Name of Medications(s): _____

_____

_____

The indications for the use of the above medication(s) have been discussed with me. I have had an opportunity to ask questions about the changes that I might expect to see, and to discuss the possible risks, benefits, and precautions associated with this/these medication(s).

The side effects of this/these medication(s) have also been discussed with me and additional information has been provided about the medication(s). I understand and accept the advantages and disadvantages of this treatment. Based upon the information provided, I agree to comply with the instructions provided by my physician for giving the medication.

I will inform the psychiatrist of any changes in medications or any new medications prescribed by another physician while under the psychiatrist's care.

If I have further questions or concerns after my child has started the medication(s), I understand that I should contact the prescribing physician as soon as possible.

_____ Date: _____/_____/_____
Parent/Legal Guardian Signature

_____ Date: _____/_____/_____
Patient Signature (for Adolescents)

_____ Date: _____/_____/_____
Physician Signature