WASHOE COUNTY DEPARTMENT OF SOCIAL SERVICES
PSYCHOTROPIC MEDICATION RECORD AND INFORMED CONSENT FOR FOSTER CHILDREN

Date: _____ Child: _____ Age: _____ DOB: _____ Page ____ of ____

Caseworker: _____ Case Name: _____ Placement: _____

Phone: _____

Contact: _____

The following medication(s) were discussed as part of a treatment plan based on a diagnosis and information from you and other sources. The accuracy of the diagnosis and safety of the treatment depends on the accuracy of the information. If there are changes, please update the prescriber. A signed consent by the youth's legally responsible party is required before administrating any medications. Do not sign the approval until all your questions are answered. I was informed of the purpose, risks, benefits, alternatives and terms of each medication. I believe this plan is in the best interests of this child and I approve of this plan. Although I understand that certain medicaitons can't be stopped quickly, I can withdraw my approval at any time.

Allergies, illnesses, and/or other medications:

Person Legally Responsible (PLR): Phone:

Signature: Date: Address:

Diagnosis:
Axis I:
Axis II:
Axis III/IV:

Target Symptoms:

Medication name and mg's	Action	# of tabs or caps	When	Purpose, expected results/outcomes:
#1	☐ NEW		in morning	
	☐ continuee		at noon	
	☐ Increase		in afternoon	
	☐ decrease		in evening	
	☐ changee		at bedtime	
	☐ STOPe		PRN	In special care instructions below, describe PRN requirements/restrictions
mg's:	Length of TX:		Expect improvement by:	

Medication exceeds limits of NRS 4328.197 by:
☐Not FDA approved ☐ under 4 y.o.
☐▲2 diff. classes ☐▲2/class

These alternatives were discussed:
☐ other medications:e
☐ counseling (type):e

Warnings and Side Effects

☐serious rash	☐voices	☐ ▲ ▼ sexual effectse
☐addictione	☐cant sleep	☐ diabetes
☐shakese ☐crampse	☐dry mouth ☐tirede	☐ ▼ effect birth control pillse ☐ birth defects
☐sleep walking	☐seizures	☐ ▲ ▼ hungrye ☐ ▲ ▼ weighte
☐heart probleme	☐agitatione	☐ frequent bathroom urgese
☐constipation	☐ ▼ memory	☐ suicide thoughts/feelingse
☐'sick to stomach'	☐driving	☐ interactions

☐ other:
☐FactSheet Provided to person legally Responsible
Initials: PLR Child (optional)

Target Symptoms:

Medication name and mg's	Action	# of tabs or caps	When	Purpose, expected results/outcomes:
#2	☐ NEW		in morning	
	☐ continuee		at noon	
	☐ Increase		in afternoon	
	☐ decrease		in evening	
	☐ changee		at bedtime	
	☐ STOP		PRN	In special care instructions below, describe PRN requirements/restrictions
mg's:	Length of TX:		Expect improvement by:	

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☐constipatione	☐ ▼ memory	☐ suicide thoughts/feelingse
☐'sick to stomach'	☐drivinge	☐ interactions

☐ other:
☐FactSheet Provided to Person Legally Responsible
Initials: PLR Child (optional)

Special care instructions/misc. notes:

Labs ordered: ☐ Next Appt. scheduled for: Physician's Signature: Date: