**Division of Child and Family Services**

**Children’s Mental Health**

**Medication Management Acknowledgement Form**

The Division of Child and Family Services is able to provide your child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, access to a DCFS psychiatrist for

(Insert name of child),

medication management purposes. This service is available only as long as your child is also receiving therapy from a DCFS Children’s Clinical Services or Early Childhood Mental Health Services therapist.

When therapeutic goals are met and therapy is no longer needed, a transition period of up to 60 days from the date of the last therapy appointment may be provided for your child to provide you time to locate medication management services from a community psychiatrist or other physician.

You will be given notice of the availability of continued DCFS psychiatric services when your child has met his or her therapeutic goals; at that time, DCFS therapy services will be terminated. Potential resources to locate a community psychiatrist or another medical doctor will be provided to you at your request at that time.

By signing below, I hereby acknowledge I have read the above notice and understand the limits of medication management provided by the Division of Child and Family Services.

Name of Legally Responsible Person (Print)

 \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legally Responsible Person Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of DCFS Staff Witness Date