

Date _____		Medication Administration Informed Consent				Page _____ of _____	
Child: _____ Age _____ Placement: _____					Allergies, illnesses, and/or other medications:		
Diagnosis: _____							
<p>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. 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. If there are changes, please update the prescriber. The signature of the person legally responsible for the psychiatric care of the child (PLR) on this form provides consent for and permission to administer psychotropic medication to the child (named above) for the medications listed below. <u>Do not sign this consent form until all your questions are answered.</u> Although I understand that certain medications can't be stopped quickly, I understand I can withdraw consent at any time.</p>							
Print Name- Person legally responsible for the psychiatric care of the child (PLR)					Phone/Address: _____		
Signature-PLR: _____ Date: _____							
Signature-Witness: _____ Date: _____							
Target Symptoms:							
Medication name and mgs	Action	# tabs or caps	When	Purpose, expected results, time frames & instructions	Warnings and Side Effects		
#1	<input type="checkbox"/> NEW		<input type="checkbox"/> morning	Purpose & Expected Results/Outcomes:	<input type="checkbox"/> serious rash	<input type="checkbox"/> shakes	<input type="checkbox"/> ▲ ▼ sexual effects
	<input type="checkbox"/> increase <input type="checkbox"/> decrease		<input type="checkbox"/> noon		<input type="checkbox"/> voices	<input type="checkbox"/> dry mouth <input type="checkbox"/> tired	<input type="checkbox"/> ▼ effect birth control pills <input type="checkbox"/> birth defects
	<input type="checkbox"/> continue		<input type="checkbox"/> afternoon	Expect improvement by:	<input type="checkbox"/> can't sleep	<input type="checkbox"/> constipation	<input type="checkbox"/> ▲ ▼ hungry <input type="checkbox"/> ▲ ▼ weight
	<input type="checkbox"/> change		<input type="checkbox"/> evening		<input type="checkbox"/> heart problem	<input type="checkbox"/> sick to stomach	<input type="checkbox"/> frequent bathroom urges <input type="checkbox"/> diabetes
	<input type="checkbox"/> STOP		<input type="checkbox"/> bedtime		<input type="checkbox"/> seizures	<input type="checkbox"/> memory	<input type="checkbox"/> suicide thoughts/feelings
mgs: PRN as needed <input type="checkbox"/> / in addition to above <input type="checkbox"/> / if needed ___ times a day, <input type="checkbox"/> at least ___ hrs apart				<input type="checkbox"/> agitation	<input type="checkbox"/> driving	<input type="checkbox"/> interactions	
Medication exceeds limits of NRS 432B.197: <input type="checkbox"/> Not FDA appv <input type="checkbox"/> Under 4 y/o <input type="checkbox"/> 3 diff classes <input type="checkbox"/> 2 /class				These alternatives were discussed: <input type="checkbox"/> other medications <input type="checkbox"/> counseling (type)		<input type="checkbox"/> DENIED <input type="checkbox"/> Factsheet Provided Initials: PLR Child (optional)	
Target Symptoms:							
Medication name and mgs	Action	# tabs or caps	When	Purpose, expected results, time frames & instructions	Warnings and Side Effects		
#2	<input type="checkbox"/> NEW		<input type="checkbox"/> morning	Purpose & Expected Results/Outcomes:	<input type="checkbox"/> serious rash	<input type="checkbox"/> shakes	<input type="checkbox"/> ▲ ▼ sexual effects
	<input type="checkbox"/> increase <input type="checkbox"/> decrease		<input type="checkbox"/> noon		<input type="checkbox"/> voices	<input type="checkbox"/> dry mouth <input type="checkbox"/> tired	<input type="checkbox"/> ▼ effect birth control pills <input type="checkbox"/> birth defects
	<input type="checkbox"/> continue		<input type="checkbox"/> afternoon	Expect improvement by:	<input type="checkbox"/> can't sleep	<input type="checkbox"/> constipation	<input type="checkbox"/> ▲ ▼ hungry <input type="checkbox"/> ▲ ▼ weight
	<input type="checkbox"/> change		<input type="checkbox"/> evening		<input type="checkbox"/> heart problem	<input type="checkbox"/> sick to stomach	<input type="checkbox"/> frequent bathroom urges <input type="checkbox"/> diabetes
	<input type="checkbox"/> STOP		<input type="checkbox"/> bedtime		<input type="checkbox"/> seizures	<input type="checkbox"/> memory	<input type="checkbox"/> suicide thoughts/feelings
mgs: PRN as needed <input type="checkbox"/> / in addition to above <input type="checkbox"/> / if needed ___ times a day, <input type="checkbox"/> at least ___ hrs apart				<input type="checkbox"/> agitation	<input type="checkbox"/> driving	<input type="checkbox"/> interactions	
Medication exceeds limits of NRS 432B.197: <input type="checkbox"/> Not FDA appv <input type="checkbox"/> Under 4 y/o <input type="checkbox"/> 3 diff classes <input type="checkbox"/> 2 /class				These alternatives were discussed: <input type="checkbox"/> other medications <input type="checkbox"/> counseling (type)		<input type="checkbox"/> DENIED <input type="checkbox"/> Factsheet Provided Initials: PLR Child (optional)	
Target Symptoms:							
Medication name and mgs	Action	# tabs or caps	When	Purpose, expected results, time frames & instructions	Warnings and Side Effects		
#3	<input type="checkbox"/> NEW		<input type="checkbox"/> morning	Purpose & Expected Results/Outcomes:	<input type="checkbox"/> serious rash	<input type="checkbox"/> shakes	<input type="checkbox"/> ▲ ▼ sexual effects
	<input type="checkbox"/> increase <input type="checkbox"/> decrease		<input type="checkbox"/> noon		<input type="checkbox"/> voices	<input type="checkbox"/> dry mouth <input type="checkbox"/> tired	<input type="checkbox"/> ▼ effect birth control pills <input type="checkbox"/> birth defects
	<input type="checkbox"/> continue		<input type="checkbox"/> afternoon	Expect improvement by:	<input type="checkbox"/> can't sleep	<input type="checkbox"/> constipation	<input type="checkbox"/> ▲ ▼ hungry <input type="checkbox"/> ▲ ▼ weight
	<input type="checkbox"/> change		<input type="checkbox"/> evening		<input type="checkbox"/> heart problem	<input type="checkbox"/> sick to stomach	<input type="checkbox"/> frequent bathroom urges <input type="checkbox"/> diabetes
	<input type="checkbox"/> STOP		<input type="checkbox"/> bedtime		<input type="checkbox"/> seizures	<input type="checkbox"/> memory	<input type="checkbox"/> suicide thoughts/feelings
mgs: PRN as needed <input type="checkbox"/> / in addition to above <input type="checkbox"/> / if needed ___ times a day, <input type="checkbox"/> at least ___ hrs apart				<input type="checkbox"/> agitation	<input type="checkbox"/> driving	<input type="checkbox"/> interactions	
Medication exceeds limits of NRS 432B.197: <input type="checkbox"/> Not FDA appv <input type="checkbox"/> Under 4 y/o <input type="checkbox"/> 3 diff classes <input type="checkbox"/> 2 /class				These alternatives were discussed: <input type="checkbox"/> other medications <input type="checkbox"/> counseling (type)		<input type="checkbox"/> DENIED <input type="checkbox"/> Factsheet Provided Initials: PLR Child (optional)	
Medication Effects, Current Status and/or Special Instructions:							
Labs ordered: <input type="checkbox"/>		Next Appt: _____		Prescriber's signature: _____		Date: _____	
Prescriber Address: _____				Prescriber Phone # _____			