Psychotropic Medication Consent Form

Date: ____________________ **Name of Client:** ___________________________________

Woodview Program: ____

Medication #1:
Prescribing Physician: _________________
Dosage & Times: _________________
Parent Concerns:
____

Medication #2:
Prescribing Physician: _________________
Dosage & Times: _________________
Parent Concerns:
____

Medication #3:
Prescribing Physician: _________________
Dosage & Times: _________________
Parent Concerns:
____

Medication #4:
Prescribing Physician: _________________
Dosage & Times: _________________
Parent Concerns:
____

The Child and Family Services Act defines the prescribed medication as (a) psychotropic drug(s). The CFSA and Woodview require that this information be provided and the necessary informed consent be given to the administrator of this medication.

I, the undersigned, understand the purpose of this medication and hereby give my permission for Woodview staff to administer this medication.

_________________________	_______________	_________________
Parent/Guardian (signature)	Relationship to Client	Witness (signature)
_________________________		_________________
Client over 12 years (signature)		Witness (signature)

- OR -

Woodview staff will not be required to administer the prescribed medication.

_________________________	_______________	_________________
Parent/Guardian (signature)	Relationship to Client	Witness (signature)
_________________________		_________________
Client over 12 years (signature)		Witness (signature)

☐ Verbal consent received from client/guardian indicated above.