# Psychotropic Medication Treatment Consent

**Purpose:** The person legally authorized to consent to medical care on behalf of a child in DFPS conservatorship uses this form to document informed consent for a new psychotropic medication. This form does not replace or substitute for any consent form required or used by a medical provider for their records or purposes.

**Directions:** After completing this form, the medical consenter provides a copy of the form to the DFPS caseworker for the child. The caseworker files it under the child's section in the case record.

| CONSENT | |
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| I am providing consent for (child/youth’s name): | PID: |
| To receive treatment for (condition being treated): | |

| MEDICATION |
| --- |
| With the following Psychotropic Medication: |
| I have received information describing:   1. The specific condition to be treated; 2. The beneficial effects on that condition expected from the medication; 3. The probable health and mental health consequences of not consenting to the medication; 4. The probable clinically significant side effects and risks associated with the medication; and   The generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reason for the proposed course of treatment.  I have been given the opportunity to ask questions.  This consent is given voluntarily and without undue influence.  I am the child's Medical Consenter.  I understand that I have the right to choose not to consent to the initiation of this medication. If I choose not to consent to medication recommended by the medical professional, I must notify the child's caseworker within 24hrs.  I understand that I have the right to withdraw consent for this treatment at any time, after consulting with the prescribing provider and the child's caseworker. |

| PRIVACY STATEMENT |
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| DFPS values your privacy. For more information, read our [Privacy and Security Policy](https://www.dfps.state.tx.us/policies/Website/). |

| SIGNATURES | |
| --- | --- |
| Medical Consenter (print name):  X | Date Signed: |
| Medical Consenter (signature):  X | Date Signed: |
| Acknowledged by Prescribing Provider or Prescribing Provider Designee (signature):  X | Date Signed: |