#   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   |
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| 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   |
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| 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:      |