Texas Department of
Family and Protective Services

Form **K-905-4526**
Revised April 2019

# CONSENT FOR TREATMENT WITH PSYCHOTROPIC MEDICATION

**Purpose:** Use this form to keep a record of informed consent for a psychotropic medication that is prescribed for a child or youth in DFPS care. This form does not replace or substitute for any form that a medical provider requires or uses for his or her purposes.

**Directions:** To complete this form, the child's medical consenter fills out all sections except the last section (*Medical Provider's Signature*). The medical consenter is the person legally authorized to consent to medical care on behalf of a child in DFPS care. The medical provider who is prescribing the medication (or his or her designee) completes the last section. The medical consenter gives a copy of the completed form to the child's caseworker. The caseworker files it under the child's section in the case record. If you have questions, please contact the child's caseworker.

| **BASIC INFORMATION** | |
|---|---|
| Child's Name: | DFPS Person ID: |
| Condition Being Treated: | |
| Psychotropic Medication Prescribed: | |

| **CONSENT** |
|---|
| I am the child's medical consenter. |
| I am providing consent for the child named above to receive treatment for the condition named above, using the psychotropic medication named above. |
| I have received information describing all of the following:<br>• The specific condition to be treated.<br>• What improvements to that condition the medication will probably cause.<br>• What will probably happen to the child's physical and mental health if he or she does not receive the medication.<br>• What side effects the medication will probably cause and what risks come with the medication.<br>• What other generally-accepted treatments exist (such as other medications or non-medication treatments), if any, and why this medication is recommended. |
| I have had the opportunity to ask questions. |
| I am following the DFPS guidelines for medical consenters voluntarily and without being pressured to do so. |
| I understand that I have the right to choose not to consent to this medication, but if I choose not to consent, I am required to notify the child's caseworker within 24 hours of making that decision. |
| I understand that I have the right to withdraw consent for this medication at any time, after consulting with the medical provider who is prescribing it and with the child's caseworker. |

| **PRIVACY STATEMENT** |
|---|
| DFPS values your privacy. For more information, read our Privacy and Security Policy. |

| **MEDICAL CONSENTER'S SIGNATURE** | |
|---|---|
| Printed Name of Medical Consenter: | |
| Signature of Medical Consenter:<br>X | Date Signed: |

| **MEDICAL PROVIDER'S SIGNATURE** | |
|---|---|
| I acknowledge that I am the medical provider who is prescribing this medication for this child (or I am the medical provider's designee), and I have had an opportunity to read this completed form. | |
| Printed Name of Medical Provider or Designee: | |
| Signature of Medical Provider or Designee:<br>X | Date Signed: |