JUVENILE JUSTICE MEDICATION CONSENT

I, _________________, am the parent/legal guardian of __________________ and have talked with my child's psychiatrist or nurse practitioner, ____________________________________, who has recommended that my child receive(s) medication(s) listed below, to treat symptoms of ______________________________.

We also talked about reasonable alternatives, such as:

____

☐ No reasonable alternatives available at this time.

The type(s) of medications prescribed is/are identified below:

Medication(s)	Type Antidepressant, Anxiolytic, Mood, Stabilizer, Antipsychotic, Other	Dosage (including PRN)	Frequency	Method (Oral/Injection)	Duration
1.					
2.					
3.					
4.					
5.					
6.					

- I understand the dosage(s), when my child should take the medication(s), and that any changes in medication dosage and/or frequency during the course of treatment will be discussed with my child and/or me.

- I have been informed that side effects are possible, including, but not limited to:
  ☐ Muscle stiffness/tremor ☐ Drowsiness ☐ Dry mouth/blurred vision/constipation
  ☐ Nausea/appetite changes ☐ Sexual problems ☐ Pregnancy issues ☐ Dizziness
  ☐ Interactions with other drugs, food & health conditions ☐ Diabetes ☐ Weight Gain
  ☐ Other (explain) ____

- I understand that these are common side effects, and that there may be other less common ones. I also understand that I should promptly inform my child's psychiatrist or nurse practitioner about any known changes in my child's condition (e.g. dizziness, severe sedation, rash), if my child becomes pregnant, and/or any new medications my child may be prescribed/take for other conditions.

- I understand that with some anti-psychotic medications, there is a possible side effect called tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso, and may persist even after stopping the medication.

- **In addition to the above mentioned side effects, I understand there may be additional long term use side effects (present after three months)** such as: ☐ None other than those listed above
  ☐ Describe long term side effects not identified above ____________________________________

- I understand that the decision for my child to take medication is up to me, but that I should always first discuss any decision to stop taking medication with my child's psychiatrist/nurse practitioner.

- I understand that my child's psychiatrist/nurse practitioner believes this medication will help my child, but there is no guarantee as to the results.

This confidential information is provided to you in accord with State and Federal laws and regulations including, but not limited to, applicable Welfare and Institutions Codes, Civil Codes and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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Complete if Parent/Legal Guardian/Conservator is present:

☐ **I HAVE READ THIS FORM** ☐ **THIS FORM HAS BEEN READ TO ME**

☐ **THIS FORM WAS INTERPRETED IN ___________________FOR ME.**

If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version.

THE INFORMATION ON THE FORM HAS BEEN EXPLAINED TO ME, AND I AGREE TO THE PROVISION OF THE MEDICATION(S) AS PRESCRIBED FOR MY CHILD. I UNDERSTAND THAT CONSENT MAY BE WITHDRAWN AT ANY TIME.

Signature: ____________________________________ **Signature:** ________________________________
(Client) (Parent/Legal Guardian/Conservator)

I HAVE EXPLAINED THE BENEFITS, SIDE EFFECTS AND RISKS OF THE MEDICATION(S) LISTED ABOVE AND HAVE OBTAINED THE PATIENT'S/RESPONSIBLE ADULT'S INFORMED CONSENT.

Signature: _____________________________________ **Date:** __________
(Psychiatrist or Nurse Practitioner and Discipline)

Complete if Parent/Legal Guardian/Conservator is NOT present:

☐ **DURING A TELEPHONE CONVERSATION ON THE DATE LISTED BELOW, I EXPLAINED THE INFORMATION ON THIS FORM INCLUDING THE BENEFITS, SIDE EFFECTS, AND RISKS OF THE MEDICATION(S) LISTED ABOVE TO ___________________, PARENT/LEGAL GUARDIAN/CONSERVATOR OF ___________________.**

☐ **THIS FORM WAS INTERPRETED IN ___________________BY ____________________________.**

☐ **THE PARENT/LEGAL GUARDIAN/CONSERVATOR OF ________________________ PROVIDED INFORMED CONSENT FOR THE PROVISION OF THE MEDICATION(S) LISTED ABOVE, AS PRESCRIBED FOR HIS/HER CHILD AND UNDERSTANDS THAT CONSENT MAY BE WITHDRAWN AT ANY TIME.**

Signature: _______________________________ **Date:** __________ **Time of call:** __________
(Psychiatrist or Nurse Practitioner and Discipline)

Witness: __________________________ **Signature:** _____________________________ **Date:** ________

A COPY OF THIS FORM SHALL BE MAILED, FAXED, OR SECURELY EMAILED* TO THE PARENT/LEGAL GUARDIAN/CONSERVATOR.

*All emails must be sent in accordance with the Policy No. 557.02 Appropriate Use of Email for Transmitting PHI and/or Confidential Data and Policy 506.02 Privacy Sanctions and all other HIPAA Privacy and Security Policies

This section to be completed by the parent/legal guardian upon receipt of this form.

Signature of Parent/Legal Guardian/Conservator: ______________________________ **Date:** __________

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