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Child, Adolescent, and Adult Psychiatrist

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Consent For Treatment With Medication

I, _______________________________ parent or guardian of _______________________________ born on _____________ , agree and consent for psychiatric treatment to include the use of medication.

I understand the potential risks and benefits of the medication as well as alternatives to medication. I also understand the risk and benefits of other treatment options including no treatment whatsoever. I understand that the risk of ________________________________ includes possible side effects of (but not limited to) ____
____.
I understand that every person reacts differently to medications and that other side effects and reactions are possible.

The medication will attempt to improve the following issues or symptoms:
____
____.
The initial dosage of________________________________ will be _____________ and the expected dosage range will be ____.

Patient Question(s) and Physicians Response(s):
____
____
____
____

I understand the information provided to me, and have been given the opportunity to discuss other treatments and to raise questions regarding the use of this medication. I will call or see my clinician promptly for any questions, problems, or concerns regarding treatment with this medication.

___________________________________ __________________
Signature Of Legal Guardian Date

___________________________________ __________________
Witness Date