UCLA Counseling & Psychological Services

Guardian/Parent Consent for Medication for a Minor

PLEASE READ THIS FORM CAREFULLY

Dr. _____ has met with me and we discussed ☐ **the conservatee's** ☐ **my child's**
(print first and last name)
illness or condition which requires treatment. The doctor has recommended treatment of this illness or condition with psychotropic medications. I have been provided with the following information by the doctor prescribing such medications:

1. The nature of the mental illness/condition

2. The reasons for taking such medications, including the likelihood of improving or not improving without such medication.

3. The reasonable alternative treatment available, if any.

4. The type, frequency, amount, method, and duration of medication treatment.

5. The side effects that this/these particular medication(s) may cause, as well as side effects which may occur because of physical or medical condition(s) that my conservatee/ child may have or interaction with other medications or foods. If the doctor has prescribed neuroleptics, he or she has discussed with me the possible complication of tardive dyskinesia, its symptoms and implications.

6. The possible consequences of abrupt discontinuation of this medication and ways to avoid these consequences.

Name of medication(s): _____

_____

_____

_____

My signature below constitutes acknowledgment that: (1) I have read and agree to the foregoing; (2) the medications and treatment set forth above have been adequately explained and/or discussed with me by my doctor, and I have received all of the information I desire concerning such medication and treatment; and (3) I authorize and consent to the administration of such medications and treatment.

Guardian's/Parent's Name	Guardian's/Parent's Signature	Date
Physician's Name	Physician's Signature	Date