New England Center for Healthy Minds
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978-679-1200
978-486-4037

Informed Consent for Medication Between Parents/Guardian

Patient name: _____ DOB: _____

Patient or Parent or Guardian: _____

Date: _____

My prescriber, _____, has discussed with my child and me the medication they are prescribing for my child. They have told us about the beneficial results, which we hope will occur. They have told us about the possible side effects. We also have discussed the physical dangers of stopping medicines abruptly and the possible bad consequences to my child's mental health if he/she stops taking these medications prematurely.

I agree to a trial of mediations for my child and understand the benefits and risks. I accept the responsibility of talking with the prescriber if my child experiences any discomforts, which may be associated with the medication. I also accept full responsibility for any adverse effects, such as recurrence of my child's symptoms, which may result for stopping, increasing, or decreasing medication without instruction from the prescriber or another person who may be acting in their place at the New England Center. I accept the responsibility of supervision of properly dispensing the medication and of storing them in a safe place in their original bottles.

I _____ give my permission to _____ (relationship to patient: _____) to make decisions regarding trial of new medication(s); adding or changing medication doses, if I am not physically present during any appointments. We strongly encourage both parents to be present for every follow up appointment.

I _____ accept the responsibility of communicating with _____ after every appointment to be updated change in the treatment plan related to medications.

Signature: _____ Date: _____