Permission for the Prescription or Alteration of a Psychotropic Medication
Richland County Children Services

Child: DOB:

Case Name: Worker/Supervisor ___________

Diagnosis: ____

CURRENT MEDICATIONS:			
Name of Medication:		Dosage Frequency	(check as applicable)
1.			☐ Begin ☐ Decrease ☐ Increase ☐ Continue ☐Discontinue
Reason for change, increase or addition			
2.			☐ Begin ☐ Decrease ☐ Increase ☐ Continue ☐ Discontinue
Reason for change, increase or addition			
3.			☐ Begin ☐ Decrease ☐ Increase ☐ Continue ☐ Discontinue
Reason for change, increase or addition			
4.			☐ Begin ☐ Decrease ☐ Increase ☐ Continue ☐ Discontinue
Reason for change, increase or addition			
5.			☐ Begin ☐ Decrease ☐ Increase ☐ Continue ☐ Discontinue
Reason for change, increase or addition			
6.			☐ Begin ☐ Decrease ☐ Increase ☐ Continue ☐ Discontinue
Reason for change, increase or addition			

Please Note: No medication change will be approved with the stated purpose of Behavior Control or Management. There must be a clinical reason for the medication that is supported medically either by an on-label use or is off-label demonstrated efficacy with the condition being treated. By asking to prescribe this medication the physician is judging any side effects to be less harmful for this patient than anticipated benefits of the medication and dosage.

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Signature of Prescribing Physician, Physician's Assistant or Nurse Practioner

____________________________________ ______________________
Printed Name Date

Employing Agency: ☐ Catalyst ☐ Mansfield Pediatrics ☐ Third Street Clinic ☐ Own Private Practice

☐ Other Please Specify):

Next Appt: ____

My consent is hereby given for the above course of treatment, as prescribed by the above named physician, physician's assistant or nurse practioner licensed to practice in the state of Ohio, to the above named child, who is in the custody of the Richland County Children Services. My relationship to the child is that of legal guardian, with such consent being authorized by Section 5153.11 of the Ohio Revised Code.

_______________________________________ _________________________________

Executive Director Date

Parental signature and agreement should be obtained prior to the director/designee signature whenever possible.

_______________________________________ _________________________________

Parent(s) Date

☐ Parent gave verbal consent on ______________ CW initials ________________________

☐ Parent not available to sign. (Please explain).

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RN: _______________ Supervisor: ___________________ Program Manager:___________________