OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Authorization for Psychotropic Medication

The prescribing physician or physician's designee completes this form when a child in Oklahoma Department of Human Services (OKDHS) custody in out-of-home placement is prescribed psychotropic medication and the physician or medical facility requires a separate and specific consent for the medication.

When the child is in OKDHS voluntary, emergency, or temporary custody and separate and specific consent for the psychotropic medication is required, the child welfare (CW) specialist makes reasonable attempts to locate the parent or legal guardian to obtain consent.

The foster parent and CW worker, therapeutic foster care (TFC), group home (GH), or specialized community home (SCH) staff, as applicable, submits this form to the county of jurisdiction county director for approval when:

- the child's parent or legal guardian declines to authorize or withdraws consent for the administration of psychotropic medication;
- reasonable attempts to locate the parent or legal guardian fails; or
- the child is in OKDHS permanent custody.

Case information

Child's name		Date of birth
KK number	Current placement	Placement type ☐ FC ☐ TFC ☐ GH ☐ SCH

CW county of placement worker	Telephone number
CW county of jurisdiction worker	Telephone number
CW county of jurisdiction supervisor	Telephone number
County of jurisdiction county director	Telephone number

Physician/psychiatrist prescribing psychotropic medication(s)	Telephone number

For each psychotropic medication prescribed, list the: (1) medication; (2) dosage; (3) related diagnosis; (4) reason for and benefit of the medication; (5) related risks; and (6) potential interaction with other prescribed or over-the-counter medications the child is currently prescribed or is taking. Use additional forms as necessary.

1. Psychotropic medication prescribed:_____

Date:	Dosage:	Diagnosis:
Reason for and benefit of the prescribed psychotropic medication:		
Risks and side effects of this medication:		

Child's currently prescribed or over-the-counter medication	Potential drug interaction with this psychotropic medication

2. Psychotropic medication prescribed: _____

Date:	Dosage:	Diagnosis:
Reason for and benefit of the prescribed psychotropic medication:		
Risks and side effects of this medication:		

Child's currently prescribed or over-the-counter medication	Potential drug interaction with this psychotropic medication

Child's currently prescribed or over-the-counter medication	Potential drug interaction with this psychotropic medication

I hereby authorize ☐ do not authorize ☐ the above-named child to receive the prescribed medication(s) as indicated on this form.

Parent or legal guardian signature		Date
Parent or legal guardian signature		Date
Signature of county director, assistant county director, or person left in charge		Date

Routing: Original – CW record
Copy – child's TFC, GH, SCH record, as applicable
Copy – child's parent(s) or legal guardian, when applicable