Consent to Psychotropic Medication Treatment for My Child:
Understanding of Clinical Treatment Guidelines and
Collaboration between Medical Psychologist and Physician

Child's Name: _____ *Date of Birth*: _____

My child is being seen at Northshore Counseling and Wellness (NCW) by David Jackson, PhD, MP, a Medical Psychologist, for the purpose of medical/ psychopharmacological intervention (meaning psychological treatment with medication, if indicated). My signature reflects my expressed and specific desire to have the Medical Psychologist manage any psychotropic medications he has prescribed for my child. The Medical Psychologist will work in collaboration and in concurrence with my child's referring or attending physician.

I understand that my child will undergo an evaluation by a Medical Psychologist. If my child meets classification criteria, he or she will be diagnosed accordingly based on the current guidelines of Diagnostic and Statistical Manual of Mental Disorder, 5th Edition (DSM-5). This process typically considers information provided to the doctor via a diagnostic interview, behavioral observations, and data obtained from laboratory and psychological instruments. I am aware that a diagnosis may be updated or changed, consistent with standards of care and any pattern of emerging and clinically valid evidence.

The medical psychologist's diagnostic impressions and treatment recommendations will be communicated with me. If pharmacological interventions are recommended as part of the treatment plan, a decision to medicate my child will be made collaboratively between parents/caregivers and the medical psychologist in an effort to improve my child's functioning. I have been informed that medications can reduce or alleviate symptoms, but do not cure illnesses. The goal of treatment is to maximize benefits and minimize risks.

I understand that the medical psychologist will carefully review the medication(s) with me and provide information about potential side effects. I understand that in certain situations, taking medication may cause physical and emotional discomfort to my child, could worsen my child's condition, or in rare instances, may even cause more serious complications such as potential misuse, abuse, or addiction and dependency; permanent damage; or death. I am aware that many prescribed medications do not have FDA-approval specifically for use in children.

I agree to work closely with my prescribing doctor and understand it is my responsibility to discuss the effects the medication is having on my child so that he/she can continue to assist me in ensuring the health and progress of my child's development. I agree to make sure that my child has taken his/her prescribed medication(s) at each follow-up appointment with the medical psychologist so that vital signs can be monitored.

I agree to notify my doctor in advance before personally making any changes to the agreed-upon treatment plan, including adjusting dosages and/or discontinuation of use, so that any changes will be made with my doctor's approval and supervision. This is done to ensure my child's safety. I understand that drug discontinuation can pose serious problems.

I indicate, by my signature below, that I have received this necessary information in order to make an informed decision on behalf of my child. I understand I may withdraw my consent at any time.

_____

Parent/Guardian Signature | Date

_____

Printed Name of Parent/Guardian

_____

Witness | Date