

Reclaiming our youth.

PROJECT DARE
Youth In Custody

CONSENT FOR USE OF PSYCHOTROPIC MEDICATION

1. Youth Under 16 years of Age – Complete this section:

I, _____, give consent to the administration
(Print Name of Parent/Legal Guardian)
of the medication(s), described on this form, to _____.
(Print Name of Young Person)

2. Youth 16 years of age or older – Complete this section:

I, _____, give consent to the administration of the medication(s), described on this form.
(Print Name of Young Person)

Name of the Medication	Purpose of Medication	Dosage	Possible Side Effects	Time of Medication

Name of Supervising Doctor: _____ Tel #: _____

Signature of Legal Guardian: _____
(If young person is under 16 years of age)

Signature of Young Person: _____
(If young person is 16 years of age or older)

Witness: _____ Date: _____