RED MOUNTAIN
FAMILY SERVICES, INC.

Approval for Medication Form

The purpose of this form is to give informed consent for medication administration to a Treatment Foster Child that is admitted in the Red Mountain Family Services, Inc. Treatment Foster Care Program. The legal custody holder is required to sign this form each time a medication change is recommended, or if the medication appointment recommends no change in the Treatment Foster Child's

Child's Name: _____ Date of Birth _____

Social Security Number: _____

Name of RMFS TFC Home the child is placed in: _____

List of Medication that are to be approved. Note Changes. Date change is to start: _____

_____

_____

_____

Reason for change (List Behaviors): _____

_____

_____

_____

Side Effect for present medications: _____

_____

_____

_____

Was Custody Holder Present: _____ If No, Please Explain _____

Does Custody Holder understand the purpose, benefits, risks, and side effects of medications: _____Yes _____No

_____

Custody Holder/ Custodian Signature Date

Verbal Date of Approval _____

_____

TFC Child if over age 14 Signature Date

_____

RMFS Treatment Coordinator's Signature Date

_____

Prescribing Physician Signature: Date

Official Property of Red Mountain Family Services, Inc.