



PARENTAL NOTIFICATION OF HEALTH-RELATED CARE: MEDICATION MANAGEMENT
(Not for Psychotropic Medications)

NAME OF YOUTH: _____ DATE OF BIRTH: _____

FACILITY NAME: _____ DJJID#: _____ DATE: _____

PARENT/GUARDIAN NAME AND ADDRESS: _____

DJJ FACILITY NAME AND ADDRESS: _____

Dear _____ :

Our records indicate that you are the parent(s) or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that a licensed health care practitioner has recommended the following medication or medication changes.

The following medication has been ordered, started or changed:

Medication: _____ times per day, by _____ for _____ days
(route)

Purpose: _____

Possible Side Effects: _____

Signature of Health Care Provider

Printed Name of Person Completing Form

If you have any concerns about the above information or do not want your child to receive this medication/treatment; notify the DJJ facility at the phone number indicated.

Phone Number: _____

Person to Contact: _____



TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS MEDICATION.

Parent/Guardian Signature

Date

** Copy of Notification to be filed in Individual Health Care Record.

