

CHOICES FOR LIFE FOSTER CARE

Authorization for Psychotropic Medication(s)

The prescribing physician completes this form when a child in Oklahoma Department of Human Services custody and foster care (FC), therapeutic foster care (TFC), group home (GH), or specialized community home (SCH) placement requires psychotropic medication(s) or a change in such medication(s). The foster parent and Child Welfare (CW) worker, or TFC, GH, or SCH staff, as applicable, submits this form to the county of jurisdiction county director following notification to the county director of the forthcoming authorization request.

Child's name		Date of birth
KK number	Current placement	Placement type <input type="checkbox"/> FC <input type="checkbox"/> TFC <input type="checkbox"/> GH <input type="checkbox"/> SCH
CW county of placement worker		Phone ()
CW county of placement worker		Phone ()
CW county of placement worker		Phone ()
CW county of placement worker		Phone ()
Physician/psychiatrist prescribing psychotropic medication(s)		Phone ()

Psychotropic medication(s) and dosage(s):

Reason for psychotropic medication(s):

Risks and benefits of psychotropic medication(s):

Potential risks and interaction of psychotropic medication(s) with other drugs:

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

_____	_____
Biological parent signature	Date
_____	_____
Biological parent signature	Date
_____	_____
County director or designee signature	Date

Routing: Original – CW case record
Copy – Child’s TFC, GH, SCH record, as appropriate
Copy – Child’s parent(s), if applicable