Community Care Resources, Inc.

Partnership in Planning

TREATMENT/MEDICATIONS INFORMED CONSENT

Name of Youth	**Date of Birth**
Foster Parents	**CCM**

1. **Treatment/Medication & <u>Anticipated Dosage Range</u>:**

2. **Reason for Treatment/Medication i.e., Medical Condition and/or Behavior:**

3. **Benefits Expected:**

4. **Potential Side Effects/Risks or Discomforts (*General & Specific*):**

Physician's Signature	**Date**

The need for and continued use of this treatment/medication will be reviewed at least every 90 days by the physician. Questions about the treatment/medication can be asked by contacting the physician or the staff designee/contact person who will make any necessary arrangements. Consent can be withdrawn at any time with written notification.

By my signature below, I give consent for the above described treatment/medication to be administered, as stated above. My signature also indicates that I understand the reasons for the treatment/medication, its potential risks and its benefits.

Parent/Legal Guardian	**Date**

Form Updated 02/2018

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