Shodair Child & Adolescent Psychiatric Services
MEDICATION AUTHORIZATION

Patient Name _____ Med. Rec. No.: _____

Admission Date: _____ Attending LIP: _____

1. I voluntarily consent to treatment with the medication(s) listed below and release the Licensed Independent Practitioner and staff of Shodair Hospital from liability for any results that may occur.

NAME OF MEDICATIONS:
(PLEASE DO NOT LIST DOSAGE)

_____

_____

_____

_____

2. I have been informed of the nature of the treatment and the most common side effects of the medication(s) prescribed. I understand that although the most common side effects of the medication(s) have been explained, there may be other side effects and that I should promptly inform the Licensed Independent Practitioner or nursing staff if there are any unexpected changes in the patient's condition.

3. The following printed medication information has been explained and given to me:
   A. Fact sheet for each medication listed above to include:
      Reasons for taking medication(s)
      - Common side effects
      - Precautions
   B. Food/drug interactions

On this basis, I authorize the attending Licensed Independent Practitiiner or anyone authorized by him/her to administer the medications listed above at such intervals and dosage as the physician deems advisable.

Date: _____ Signed: _____
(Parent or Legal Guardian)

Date: _____ Signed: _____
(Patient)

Date: _____ Phone Consent Obtained From:_____
(Parent/Legal Guardian)

Date: _____ Signed: _____
(LIP or R.N. witness to Phone Consent)