Psychotropic Medication Consent Form Anti-anxiety

| Youth's name | Date | Date of Birth | |
|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | (Please Print) | |
| Name of Medication | Dosage Ran | ge | |
| | st will prescribe, and I will take this med ake this medication as prescribed every of | | |
| | | | |
| | | | |
| | | | |
| regarding the information. If I nurse: POSSIBLE SIDE EFFE effects than those expected: ex | ctitement, irritability, dizziness, anger, anavior, memory loss, dry mouth, blurred | I will report them to a doctor or ications cause the opposite ggression, trouble sleeping, | |
| WARNING: Stopping this n | nedication suddenly may cause cramps, somere, restlessness, trouble sleeping or sha | seizures, depression, hearing | |
| Parent/Guardian contact- Telep | | Results of contact: | |
| Davison of Food and Deve Adve | iniatuation approval atotus for this modifies | notion | |
| Keview of Food and Drug Adm | ninistration approval status for this medic | zauon. | |
| Youth's Signature | Psychiatrist's Signature | Date | |

Form X1.32.A.1 Anti-anxiety Effective Date: 02/01/09 Page 1 of 1

Psychotropic Medication Consent Form Antihistamines

| Youth's name | | Date of Birth | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | (Please Print) | |
| Name of Medication | Dosag | ge Range | |
| | | s medication as a part of my mental every day, it should help with these | |
| | | | |
| | | | |
| | | | |
| regarding the information. If I have nurse: COMMON SIDE EFFECT trouble concentrating, dry mountains the concentration of the concentra | | ess of appetite tics (fast repeated movements), | |
| | IOUS: Worsening of asthma or t | | |
| uncontrollable behavior, severe | e muscle stiffness | | |
| Parent/Guardian contact- Teleph | none number: | Results of contact: | |
| Review of Food and Drug Adm | inistration approval status for this | medication. | |
| Youth's Signature Form XI.32.A.2 Antihistamines | Psychiatrist's Signat | ture Date | |

Psychotropic Medication Consent Form Beta-Blockers

| Youth's name | Date of Birth | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | (Please Print) |
| Name of Medication | Dosage Range | |
| I understand that my psychiatris health treatment program. If I tatarget symptoms: | t will prescribe, and I will take this medication ake this medication as prescribed every day, it | n as a part of my mental should help with these |
| | | |
| | | |
| My psychiatrist has reviewed th regarding the information. If I h nurse: OCCASIONAL SIDE El dizziness; slow heartbeat, low LESS COMMON: Sadnes rash, muscle cramps | an information sheet regarding the medication e information with me. I was given the oppornave the following or other side effects, I will FFECTS: Tiredness, numbing, cold, or pain blood pressure as or irritability, nausea, trouble sleeping or nighthand or trouble breathing, wheezing, seeing contact the statement of the state | tunity to ask questions report them to a doctor or in the fingers or toes: ghtmares, diarrhea, skin |
| not there, heart failure | | |
| Parent/Guardian contact - Telep | medication suddenly may cause a dangerous r | Results of contact: |
| Review of Food and Drug Adm | inistration approval status for this medication | , |
| Youth's Signature | Psychiatrist's Signature | Date |

Form X1.32.A.3 Beta-blockers Effective Date: 02/10/09 Page 1 of 1

Psychotropic Medication Consent Form Buspar

| Youth's name | | Date of Birth | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------|
| Psychiatrist: Dr | | | (Please Print) |
| Name of Medication | Dos | sage Range | |
| I understand that my psychiatrist whealth treatment program. If I take target symptoms: | | | |
| | | | |
| | | | |
| I know the medication will be start I understand that laboratory exami required. I have been provided an My psychiatrist has reviewed the i regarding the information. If I have nurse: | nations, including blood wor information sheet regarding nformation with me. I was g | k and an Electrocardithe medication that hiven the opportunity | iogram, may be as been prescribed. to ask questions |
| POSSIBLE SIDE EFFECT these medications can cause the opmemory loss | | | |
| Parent/Guardian contact- Telephor | ne number: | | Results of contact: |
| Review of Food and Drug Admini | istration approval status for tl | nis medication. | |
| Youth's Signature | Psychiatrist's Sign | nature | Date |

Form XI.32.A.4 Buspar Effective Date: 02/10/09 Page 1 of 1

Psychotropic Medication Consent Form Clonidine [Catapres] and Guanfacine [Tenex]

| Youth's name | Date of Birt | Date of Birth | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | (Please Print) | |
| Name of Medication | Dosage Range | | |
| | st will prescribe, and I will take this medication take this medication as prescribed every day, it s | | |
| | | | |
| | started at a low dose to make sure I have as few | | |
| required. I have been provided My psychiatrist has reviewed the regarding the information. If I nurse: OCCASIONAL SIDE E Disorder, trouble sleeping, rin | aminations, including blood work and an Electron an information sheet regarding the medication the information with me. I was given the opportunity that the following or other side effects, I will respect to the same and its s | that has been prescribed unity to ask questions eport them to a doctor on a gof tics in Tourette's | |
| constipation, dry mouth, dizzi | | | |
| | FFECTS: Sleepiness, fatigue, low pressure, ag | | |
| | ssion, confusion, bed-wetting, muscle cramps, it | | |
| | RIOUS: Fainting, irregular heartbeat, trouble be of urination, swelling of body, sudden headaches | | |
| WARNING: Stopping this temporary worsening of behavior | medication suddenly may cause a dangerous risvioral problems or tics; nervousness or anxiety; ne; stomach cramps (nausea, vomiting), trouble s | rapid or irregular | |
| Parent/Guardian- contact. Tele | | Results of contact | |
| Review of Food and Drug Adn | ninistration approval status for this medication. | | |
| Youth's Signature Form XI.32.A.5 Catapres & Tenex | Psychiatrist's Signature Effective Date: 02/10/09 | Date Page 1 of 1 | |

Psychotropic Medication Consent Form Cymbalta

| Youth's name | Date of Birth |
|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | (Please Print) |
| Name of Medication | Dosage Range |
| | e, and I will take this medication as a part of my mental ation as prescribed every day, it should help with these |
| | |
| I understand that laboratory examinations, increquired. I have been provided an information My psychiatrist has reviewed the information | dose to make sure I have as few side effects as possible. luding blood work and an Electrocardiogram, may be a sheet regarding the medication that has been prescribed with me. I was given the opportunity to ask questions wing or other side effects, I will report them to a doctor of |
| COMMON SIDE EFFECTS: Nausea sleeping, constipation, tiredness | , sleepiness, headaches, dry mouth, dizziness, trouble |
| LESS COMMON: Diarrhea, loss of app | etite, sore throat, runny nose, weakness, sweating, arred vision, anxiety, agitation, hot flashes, yawning, |
| | ain, acne, sensitivity to the sun, high blood pressure |
| | ngs of happiness or depression, seeing or hearing things iveness, trouble urinating, heart failure, very fast heart |

adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children,

| Parent/Guardian contact- Telephone | number: | Results of contact: |
|------------------------------------|-------------------------------------|---------------------|
| | | |
| | | |
| D CE 1 1D Alexander | | J:4: |
| Review of Food and Drug Administ | ration approval status for this med | incation. |
| | | |
| Youth's Signature | Psychiatrist's Signature | Date |

Form XI.32.A.6 Cymbalta Effective Date: 02/10/09 Page 2 of 2

Medical Services Psychotropic Medication Consent Form Anticonvulsants: Depakote

| Youth's name | uth's name Date of Birth | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | (Please Print) |
| Name of Medication | Dosage Range | |
| | ill prescribe, and I will take this medication this medication as prescribed every day, it s | |
| | | |
| I understand that laboratory examine required. I have been provided an important of the interest of the intere | ed at a low dose to make sure I have as few thations, including blood work and an Electroninformation sheet regarding the medication of information with me. I was given the opportune the following or other side effects, I will restrict the following or other side effects, I will restrict the following or other side effects, I will restrict the following or other side effects, I will restrict the following or other side effects, I will restrict the following or other side effects, I will restrict the following or other side effects, I will restrict the following or other side effects, I will restrict the following of the paner of the following of the paner of the following weak or unusually tired, loss of approximation of the paner of the following of legs, feet or face of the following and bleeding; sore throat; in seizure, severe behavioral problems; mental effects if given to pregnant women | ceardiogram, may be that has been prescribed. Unity to ask questions eport them to a doctor or veight gain, thinning arregular menstrual sion problems reas (severe abdominal petite, yellowing of e; greatly increased or nouth ulcers; vomiting; |
| WARNING: Some mood stability | izers have been associated with an increase i | in suicidal thoughts |
| Parent/Guardian contact - Telephon | ne number: | Results of contact: |
| Review of Food and Drug Adminis | stration approval status for this medication. | |
| Youth's Signature Form X1.32.A.7 Depakote | Psychiatrist's Signature Effective Date: 02/10/09 | Date Page 1 of 1 |

Medical Services Psychotropic Medication Consent Form Effexor [venlafaxine]

| Youth's name | | Date of Bir | th |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------|
| Psychiatrist: Dr | | | (Please Print) |
| Name of Medication | | Dosage Range | |
| I understand that my psychiatrist with health treatment program. If I take target symptoms: | - | | |
| | | | |
| | | | |
| I know the medication will be started I understand that laboratory examinarequired. I have been provided an in My psychiatrist has reviewed the integrating the information. If I have nurse: | nations, including bloo information sheet rega nformation with me. I | d work and an Electrording the medication was given the opport | ocardiogram, may be that has been prescribed. unity to ask questions |
| OCCASIONAL SIDE EFFE | • | usness, nausea, sleep | iness, insomnia, |
| decreased appetite, weight loss, weakness LESS FREQUENT: Yawning, blurred vision, dry mouth, dizziness, constipation, excessi sweating, lack of energy, trouble with sexual functioning | | tipation, excessive | |
| LESS COMMON BUT MORE SERIOUS: Increased blood pressure, seizures | | e, seizures | |
| WARNING: Do not give MAOI's, stopping suddenly may cause flu-like symptoms | | ymptoms | |
| THE COLOR DO NOT GIVE THE CO. | is, stepping sacremy | | |
| WARNING: All antidepressants adolescents and young adults. How these populations is associated with | wever, studies have for | and that increased use | |
| Parent/Guardian contact- Telephone number: Results of contact: | | sults of contact: | |
| Review of Food and Drug Adminis | stration approval statu | s for this medication. | |
| Youth's Signature | Psychiatrist | 's Signature | Date |

Form X1.32.A.8 Effective Date: 02/10/09 Page 1 of 1

Medical Services

Psychotropic Medication Consent Form Klonopin [clonazepam]

| Youth's name | Date | Date of Birth | |
|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | (Please Print) | |
| Name of Medication | Dosage Rar | nge | |
| | will prescribe, and I will take this med e this medication as prescribed every | | |
| | | | |
| | | | |
| | | | |
| I understand that laboratory examined required. I have been provided an My psychiatrist has reviewed the interest of the system of the system. | ted at a low dose to make sure I have inations, including blood work and an information sheet regarding the med information with me. I was given the ve the following or other side effects, | Electrocardiogram, may be lication that has been prescribed. copportunity to ask questions | |
| | S: Difficulty with balance, drowsines gression, trouble sleeping or nightman | | |
| | avior, depression if combined with ale | | |
| 11 0 | dication suddenly may cause; Cramps estlessness, trouble sleeping or shakir | | |
| WARNING: May be habit form | ming | | |
| | ne number: | Results of contact: | |
| Review of Food and Drug Admin | nistration approval status for this medi | ication. | |
| Youth's Signature | Psychiatrist's Signature | Date | |

Form X1.32.A.9 Klonipin Effective Date: 12/15/08 Page 1 of 1

Medical Services Psychotropic Medication Consent Form Lamictal

| Youth's name | Date of | Date of Birth | |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | (Please Print) | |
| Name of Medication | Dosage Range | | |
| | t will prescribe, and I will take this medica ake this medication as prescribed every day | | |
| | | | |
| | | | |
| I understand that laboratory examples are a sequired. I have been provided a My psychiatrist has reviewed the | carted at a low dose to make sure I have as minations, including blood work and an Elean information sheet regarding the medicate information with me. I was given the oppose the following or other side effects, I was a sure or other side effects. | ectrocardiogram, may be ion that has been prescribed. portunity to ask questions | |
| COMMON SIDE EFFEC | TS: Sleepiness, dizziness, headache, doub | | |
| | or nervousness, agitation or mania, dry mou OUS: Vomiting, change in color of urine | | |
| severe skin rash | | | |
| of skin or eyes, dark urine or padecreased frequency of urination | S: Feeling weak or sick or unusually tired le bowel movements, swelling of legs, feet n, unusual bruising or bleeding, sore throat, severe behavioral problems, mental confu | , or face, greatly increased or , mouth ulcers, vomiting, | |
| These rashes are more common | us, sometimes fatal skin rash may occur wh in children under 16 (sixteen). Immediate | | |
| develop any type of rash. | | | |
| WARNING: Some mood sta | bilizers have been associated with an incre | ase in suicidal thoughts | |
| | hone number: | | |
| Review of Food and Drug Adm | inistration approval status for this medicat | ion. | |
| Youth's Signature | Psychiatrist's Signature | Date | |

Effective Date: 02/10/09

Page 1 of 1

Form X1.32.A.10

Medical Services

Psychotropic Medication Consent Form Lithium

| Youth's name | | | Date of Birth | |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | | (Please Print) | |
| Name of Medication | | — Dosage | e Range | |
| | | | medication as a part of my mental very day, it should help with these | |
| | | | | |
| | | | | |
| | | | | |
| My psychiatrist has reviewed regarding the information. nurse: COMMON SIDE EFF | ed the information If I have the follow FECTS: Weight § | with me. I was given wing or other side eff gain, stomachache, di | medication that has been prescribed. In the opportunity to ask questions feets, I will report them to a doctor or diarrhea, nausea, vomiting, mild of hands, tiredness, headache, | |
| | decreased school | performance, acne, sl | roid) tiredness, feeling cold, weight kin rash, hair loss, bed-wetting, | |
| LESS COMMON BU' vomiting or diarrhea, weak | T MORE SERI | IOUS—CALL To lination, unsteadiness | HE DOCTOR IF: Persistent s when standing or walking, severe speaking or slurred speech, confusion | |
| SEVERE TOXIC EFI staggering, blurred vision, seizure, unconsciousness V | EVERE TOXIC EFFECTS OF TOO MUCH LITHIUM: Irregular heartbeat, fainting aggering, blurred vision, ringing or buzzing sound, inability to urinate, muscle twitches, high fever izure, unconsciousness WARNING- dehydration can lead to the symptoms stated above | | IUM: Irregular heartbeat, fainting, rinate, muscle twitches, high fever, the symptoms stated above | |
| | e amounts of coffee, tea, cola, or excessive sweating, which can cause | | | |

Form XI.32.A.11 Lithium Effective Date: 02/10/09 Page 1 of 2

Warning: Some mood stabilizers have been associated with an increase in suicidal thoughts

| Parent/Guardian contact- Telephon | Results of contact: | |
|-----------------------------------|---------------------------------------------|------|
| Review of Food and Drug Adminis | tration approval status for this medication | on. |
| Youth's Signature | Psychiatrist's Signature | Date |

Form X1.32.A.11 Lithium Effective Date: 02/10/09 Page 2 of 2

Medical Services

Psychotropic Medication Consent Form Anticonvulsants: Neurontin

| Youth's name | \overline{D} | Date of Birth | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr. | | (Please Print) | |
| Name of Medication | Dosage F | Range | |
| I understand that my psychiatrist will prescribe, and I will take this medication as a part of rhealth treatment program. If I take this medication as prescribed every day, it should help varget symptoms: | | • | |
| | | | |
| | | | |
| I understand that laboratory example required. I have been provided a My psychiatrist has reviewed the | arted at a low dose to make sure I had ninations, including blood work and an information sheet regarding the magnificant with me. I was given the averthe following or other side effectives. | an Electrocardiogram, may be edication that has been prescribed. The opportunity to ask questions | |
| COMMON SIDE EFFEC | rs: Sleepiness, dizziness, itchy runifeeling tired, double vision, tremor, | The state of the s | |
| | TIONAL: Worsening of behavior on, irritability | ral problems, temper tantrums, | |
| WARNING: Some mood stab | pilizers have been associated with an | increase in suicidal thoughts | |
| Parent/Guardian contact- Teleph | one number: | Results of contact: | |
| | | | |
| Review of Food and Drug Admi | nistration approval status for this me | edication. | |
| Youth's Signature Form XI.32 A.12 Neurontin | Psychiatrist's Signature Effective Date: 02/10/09 | Date Page 1 of 1 | |

Medical Services

Psychotropic Medication Consent Form Lithium

| Youth's name | | | Date of Birth | |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | | (Please Print) | |
| Name of Medication | | Dosage I | Range | |
| I understand that my psychiatris health treatment program. If I t target symptoms: | st will prescribe, and I ake this medication as | will take this n s prescribed eve | nedication as a part of my mental ery day, it should help with these | |
| | | | | |
| | | | | |
| | | | | |
| My psychiatrist has reviewed the regarding the information. If I nurse: COMMON SIDE EFFECT increased thirst, increased frequency. | an information sheet he information with m have the following or CTS: Weight gain, sto | regarding the me. I was given other side effections | dedication that has been prescribed. the opportunity to ask questions ets, I will report them to a doctor or or thea, nausea, vomiting, mild | |
| dizziness | | · · · · · · · · · · · · · · · · · · · | | |
| gain, dry skin, coarser hair, dec change in blood sugar, metallic | creased school perform | nance, acne, ski | id) tiredness, feeling cold, weight n rash, hair loss, bed-wetting, | |
| LESS COMMON BUT No vomiting or diarrhea, weakness | MORE SERIOUS- s, lack of coordination | —CALL TH, unsteadiness v | E DOCTOR IF: Persistent when standing or walking, severe eaking or slurred speech, confusion | |
| | | | JM: Irregular heartbeat, fainting, | |
| - | | | nate, muscle twitches, high fever, | |
| seizure, unconsciousness WA | • | | • • | |
| AVOID drinking large amoundehydration. Taking NSAIDs | | | | |

Form XI.32.A.11 Lithium Effective Date: 02/10/09 Page 1 of 2

Warning: Some mood stabilizers have been associated with an increase in suicidal thoughts

| Parent/Guardian contact- Telephone | number: | Results of contact: |
|------------------------------------|-------------------------------------------|---------------------|
| Review of Food and Drug Administra | ation approval status for this medication | n. |
| Youth's Signature | Psychiatrist's Signature | Date |

Form X1.32.A.11 Lithium Effective Date: 02/10/09 Page 2 of 2

Medical Services

Psychotropic Medication Consent Form Anticonvulsants: Neurontin

| Youth's name | Date of | Date of Birth | |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | | (Please Print) | |
| Name of Medication | Dosage Range | ; | |
| | vill prescribe, and I will take this medica this medication as prescribed every day | | |
| | | | |
| | | | |
| I understand that laboratory examinequired. I have been provided an My psychiatrist has reviewed the in | ted at a low dose to make sure I have as nations, including blood work and an E information sheet regarding the medican formation with me. I was given the or we the following or other side effects, I was given the order. | lectrocardiogram, may be ation that has been prescribed. opportunity to ask questions | |
| | S: Sleepiness, dizziness, itchy runny no beling tired, double vision, tremor, fever | | |
| | IONAL: Worsening of behavioral properties irritability | oblems, temper tantrums, | |
| WARNING: Some mood stabil | izers have been associated with an incre | ease in suicidal thoughts | |
| Parent/Guardian contact- Telephor | ne number: | Results of contact: | |
| | | | |
| Review of Food and Drug Admini | stration approval status for this medicat | cion. | |
| Youth's Signature Form XI.32.A.12 Neurontin | Psychiatrist's Signature Effective Date: 02/10/09 | Date Page 1 of 1 | |

Medical Services

Psychotropic Medication Consent Form Remeron

| Youth's name | Date | e of Birth |
|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | (Please Print) |
| Name of Medication | Dosage Ran | nge |
| | will prescribe, and I will take this med this medication as prescribed every | |
| | | |
| | | |
| I understand that laboratory exam required. I have been provided an My psychiatrist has reviewed the | arted at a low dose to make sure I have ninations, including blood work and ar information sheet regarding the med information with me. I was given the ave the following or other side effects, | Electrocardiogram, may be ication that has been prescribed. opportunity to ask questions |
| COMMON SIDE EFFECT | ΓS: Sleepiness, weight gain, nausea, in | ncreased appetite, dry mouth |
| OCCASIONAL: Dizziness, c | constipation, lack of energy, tiredness, | frequent urination |
| | g or diarrhea, confusion, seizure, infect movements, increased irritability, abr | |
| WARNING: Avoid taking wit | | |
| | | |
| | nts may carry the risk of increasing sur owever, studies have found that increa rith a decreased in suicides | |
| Parent/Guardian contact- Telepho | one number: | Results of contact: |
| Review of Food and Drug Admir | nistration approval status for this medi | ication. |
| Youth's Signature | Psychiatrist's Signature | Date |

Effective Date: 02/10/09

Page 1 of 1

Form XI.32.A.13

Medical Services

Psychotropic Medication Consent Form Antipsychotics

| Youth's name | Date of Birth |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | (Please Print) |
| Name of Medication | Dosage Range |
| , , , | scribe, and I will take this medication as a part of my mental edication as prescribed every day, it should help with these |
| | |
| | |
| required. I have been provided an information My psychiatrist has reviewed the information. If I have the nurse: | i, including blood work and an Electrocardiogram, may be ation sheet regarding the medication that has been prescribed tion with me. I was given the opportunity to ask questions ollowing or other side effects, I will report them to a doctor of the contraction |
| Anxiety, dry mouth, sleepiness, constip gain, decreased sexual interest or ability discharge from the breasts, drooling, sa | ion, mild trouble urinating, blurred vision, dizziness, weight changes in menstrual cycle, increase in breast size or ness, irritability, nervousness, clinginess, increased risk of ess or inability to sit still, shaking of hands of fingers, |
| RARE: Not being able to control face | arm or leg movements |
| | t but not sweating or excessive sweating, fainting, trouble bounding heart beat, high fever with rigid muscles, trouble |
| WARNING: May worsen glaucoma medicine is stopped | may cause rhythmic movements that may not stop when the |
| WARNING: May cause agranulocyt | sis |
| | ines you seriously consider the use of this medication. You ontinuing this medication with your OB/GYN physician if |

Form XI.32.A.14 SGA Effective Date: 02/10/09 Page 1 of 2

you are pregnant and/or breastfeeding

| Parent/Guardian contact- Telephone | number: | Results of contact: |
|------------------------------------|-------------------------------------|---------------------|
| | | |
| | | |
| Review of Food and Drug Administra | ation approval status for this medi | cation. |
| Ç | •• | |
| | | |
| Youth's Signature | Psychiatrist's Signature | Date |

Form XI.32.A.14 SGA Effective Date: 02/10/09 Page 2 of 2

Medical Services

Psychotropic Medication Consent Form SSRIs

| Youth's name | Date of Birth | |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Psychiatrist: Dr | (Please Print) | |
| Name of Medication | Dosage Range | |
| | ist will prescribe, and I will take this medication as a part of my mental take this medication as prescribed every day, it should help with these | |
| | | |
| | | |
| | | |
| I understand that laboratory exam required. I have been provided an My psychiatrist has reviewed the | red at a low dose to make sure I have as few side effects as possible. Inations, including blood work and an Electrocardiogram, may be information sheet regarding the medication that has been prescribed. Information with me. I was given the opportunity to ask questions the following or other side effects, I will report them to a doctor or | |
| nervousness, insomnia, restlessne | S: Nausea, upset stomach, diarrhea, headache, anxiety or s, dry mouth, dizziness, tremor or shakiness, excessive sweating, nterest or trouble with sexual functioning, weight loss, weight gain, | |
| LESS COMMON BUT MO | RE SERIOUS: Increased activity, rapid speech, feeling "speeded ag very excited or irritability (cranky), easy bruising, bleeding | |
| | RIOUS: Seizure, heatstroke, stiffness, high fever, confusion, tremors (shaking), severe rash | |
| Warning: Stopping this medica | ion suddenly may cause; flu-like symptoms | |

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Warning: Do not take with an MAOI, or take and MAOI within 5 (five) weeks of stopping

Symbyax. Do not take with Pimozide or Thioridazine

Form X1.32.A.15 SSR1 Effective Date: 02/10/09 Page 1 of 2

| Parent/Guardian contact- Telephon | e number: | Results of contact: |
|-----------------------------------|----------------------------------------|---------------------|
| | | |
| | | |
| | | |
| Review of Food and Drug Adminis | stration approval status for this medi | ication. |
| | | |
| Youth's Signature | Psychiatrist's Signature | Date |

Form XI.32.A.15 SSRI Effective Date: 02/10/09 Page 2 of 2

Medical Services

Psychotropic Medication Consent Form Stimulants

| X7 .15 | | D (CD' 4 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| Youth's name | | Date of Birth |
| Psychiatrist: Dr | | (Please Print) |
| Name of Medication | Dosage | Range |
| I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms: | | |
| | | |
| I understand that laboratory examinequired. I have been provided an My psychiatrist has reviewed the i | inations, including blood work an information sheet regarding the information with me. I was given | medication that has been prescribed. |
| COMMON SIDE EFFECT stomachaches, nervousness, crying | * * | oss, nausea, insomnia, headaches, |
| LESS COMMON: Irritability | y (crankiness), rebound (hyperact, stuttering, motor or vocal tics (f | ivity as medicine wears off), ast repeated movements or sounds), |
| RARE BUT SERIOUS: Must auditory, visual or tactile hallucing behavior that is very unusual for y | scle cramps or twitches, sadness to ations (hearing, seeing or feeling your child, yellowing of the skin of | things that are not there) any |
| Warning: Do not take within 14 | 1 (fourteen) days of an MAOI | |

Form XI.32.A.16 Stimulants Effective Date: 02/10/09 Page 1 of 2

doctor's order

Warning: Chronic abuse can lead to psychological dependence; do not increase your dose without a

Parent/Guardian contact- Telephone number: _______ Results of contact: Review of Food and Drug Administration approval status for this medication. Youth's Signature Psychiatrist's Signature Date

Warning: Some stimulants have been associated with an increase in suicidal thoughts

Form X1.32.A.16 Stimulants Effective Date: 02/01/09 Page 2 of 2

Medical Services

Psychotropic Medication Consent Form Strattera (Atomoxetine)

| Youth's name | Date of Birth | | rth |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------|
| Psychiatrist: Dr. | | | (Please Print) |
| Name of Medication | | Dosage Range | |
| I understand that my psychiatris health treatment program. If I t target symptoms: | - | | - · · · · · · · · · · · · · · · · · · · |
| | | | |
| | | | |
| I know the medication will be s I understand that laboratory exa required. I have been provided My psychiatrist has reviewed th regarding the information. If I nurse: | aminations, including blood an information sheet regar ne information with me. I | d work and an Electr ding the medication was given the oppor | rocardiogram, may be that has been prescribed. tunity to ask questions |
| COMMON SIDE EFFECT abdominal pain, dry mouth | CTS: Sleepiness or trouble | e sleeping, nausea, le | oss of appetite, upper |
| LESS COMMON: Indiges | tion, headache, constipatio | n, facial tics, | |
| RARE: Growth problems, dia attack of low blood pressure, ag | - | veight loss, crying, r | mood swings, sudden |
| RARE BUT SERIOUS: Poseeing or hearing things that are | | | or eyes) |
| Warning: Some stimulants h | ave been associated with a | n increase in suicida | al thoughts |
| Warning: Do not take with M | MAOI's, avoid if you have | narrow angle glauco | oma |
| Parent/Guardian contact- Telep | | | |
| Review of Food and Drug Adm | ninistration approval status | for this medication | |
| Youth's Signature | Psychiatrist' | s Signature | Date |

Form XI.32.A.17 Strattera Effective Date: 02/10/09 Page 1 of 1

Medical Services

Psychotropic Medication Consent Form Symbyax

| Youth's name | | Date of Birth |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | (Please Print) |
| | | |
| Name of Medication | | Dosage Range |
| | | take this medication as a part of my mental cribed every day, it should help with these |
| | | |
| | | |
| | | |
| required. I have been provid My psychiatrist has reviewed | led an information sheet regard d the information with me. I w | work and an Electrocardiogram, may be ding the medication that has been prescribed was given the opportunity to ask questions side effects, I will report them to a doctor or |
| Anxiety, dry mouth, sleeping gain, loss of appetite and we increase in breast size or dis- clinginess, increased of sunb | ess, constipation, mild trouble ight loss, decreased sexual intecharge from the breasts, drooli | LY SERIOUS SIDE EFFECTS: urinating, blurred vision, dizziness, weight erest or ability, changes in menstrual cycle, ng, sadness, irritability, nervousness, stlessness or inability to sit still, shaking of weak, trouble concentrating |
| LESS COMMON: Nigh | ntmares, stuttering, increased r | isk of sunburn, nervousness, shakiness, |
| high cholesterol or triglyceri | | |
| f · | | eased activity, rapid speech, feeling l or irritability (cranky), easy bruising, |
| RARE: Fainting, high or l | ow blood pressure, not being | able to control face, arm or leg movements |
| breathing, trouble swallowing | | g or excessive sweating, fainting, trouble eat, high fever with rigid muscles, diabetes le thinking clearly, seizures |

Form XI.32.A.18 Symbyax Effective Date: 02/10/09 Page 1 of 2

WARNING: Stopping this medication suddenly may cause flu-like symptoms

WARNING: In light of ACOG guidelines you should discuss the risks and benefits of continuing this medication if you are pregnant and/or breastfeeding

WARNING: May worsen glaucoma; may cause rhythmic movements that may not stop when the medicine is stopped; liver problems in extreme cases leading to coma or death

WARNING: Do not take with an MAOI, or take and MAOI within 5 (five) weeks of stopping Symbyax. Do not take with Pimozide or Thioridazine

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

| Parent/Guardian contact- Telephone number | er: | Results of contact: |
|-------------------------------------------|----------------------------------|---------------------|
| | | |
| | | |
| Review of Food and Drug Administration | approval status for this medicat | ion. |
| - | | |
| | | |
| Youth's Signature | Psychiatrist's Signature | Date |

Form XI.32.A.18 Symbyax Effective Date: 02/10/09 Page 2 of 2

Medical Services

Psychotropic Medication Consent Form Anticonvulsants: Tegretol

| Youth's name | | D | ate of Birth |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | | (Please Print) |
| Name of Medication | | Dosage R | Range |
| I understand that my psychiatrist health treatment program. If I tatarget symptoms: | | | |
| | | | |
| | | | |
| | | | |
| My psychiatrist has reviewed the | an information sheet regare information with me. In ave the following or other | was given the received side effective. | edication that has been prescribed. he opportunity to ask questions ts, I will report them to a doctor or |
| nausea, mild decrease in white b | • · · · · · · · · · · · · · · · · · · · | | · · · · · · · · · · · · · · · · · · · |
| LESS COMMON: Aching increased sweating, irritation or problems in males, stomach pain nervousness, behavioral changes | soreness of tongue or mon, increased sensitivity to | outh, loss of | appetite, loss of hair, sexual |
| VERY RARE BUT SERIO | | per of blood | cells, worsening of seizures, |
| severe skin rash, low sodium ir | the blood, congestive he | eart failure | |
| yellowing of skin or eyes, dark increased or decreased frequence ulcers; vomiting; persistent ston problems, depression, hearing v | urine or pale bowel move by of urination; unusual be nachache; skin rash espec | ements, swel ruising and l cially with fe | ling of ;legs, feet or face; greatly bleeding; sore throat/fever; mouth ever, seizure, severe behavioral |
| Warning: May make birth co | entrol pills less effective | | |

Form XI.32.A.19 Tegretol Effective Date: 02/10/09 Page 1 of 2

Warning: May cause birth defects when used in pregnant women

Warning: Some mood stabilizers have been associated with an increase risk of suicidal thoughts

| Parent/Guardian contact-Telephone nu | mber: | Results of contact: |
|--------------------------------------|-----------------------------------|---------------------|
| | | |
| D : (C) 1 - 1 D - Al-:::h | i | |
| Review of Food and Drug Administrat | ion approvai status for this medi | cation. |
| Youth's Signature | Psychiatrist's Signature | Date |

Form X1.32.A.19 Tegretol Effective Date: 02/01/09 Page 2 of 2

Medical Services

Psychotropic Medication Consent Form Anticonvulsants: Topamax

| Youth's name | | Date of Bir | rth |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | | (Please Print) |
| Name of Medication | | Dosage Range | |
| I understand that my psychiatris health treatment program. If I t target symptoms: | st will prescribe, and I wake this medication as p | vill take this medication prescribed every day, it | n as a part of my mental should help with these |
| | | | |
| I know the medication will be so I understand that laboratory example required. I have been provided My psychiatrist has reviewed the regarding the information. If I nurse: COMMON SIDE EFFECT and needles, fatigue, nausea, many laboratory and recommendation. | aminations, including blan information sheet rene information with me. have the following or of the company of | ood work and an Electrication garding the medication. I was given the opporther side effects, I will ess, slowed movement | rocardiogram, may be a that has been prescribed. tunity to ask questions report them to a doctor or as, skin feeling like "pins" |
| LESS COMMON: Back paleg pain, taste changes, irritabil | | | ashes, increased sweating, |
| POSSIBLY DANGEROU unexplained fever (chills and/o trouble breathing or rapid breat temperature with decreased sw | JS: Clumsiness or poor r sore throat), sharp bac thing, blood clots, fainting | coordination, bloody of the coordination, blurred or doub | le vision or eye pain, |
| Warning: Some mood stabil | izers have been associat | ed with an increase in | suicidal thoughts |
| Parent/Guardian contact- Telep | phone number: | Re | esults of contact: |
| Review of Food and Drug Adn | ninistration approval sta | tus for this medication. | |
| Vouth's Signature | Pevchiatr | st's Sionature | Date |

Effective Date: 02/10/09

Form XI.32.A.20 Topamax

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Medical Services Psychotropic Medication Consent Form Desyrel (Trazadone)

| Youth's name | Da | ate of Birth |
|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | (Please Print) |
| Name of Medication | Dosage Ra | ange |
| | t will prescribe, and I will take this meake this medication as prescribed every | |
| | | |
| I understand that laboratory examples are a sequired. I have been provided a My psychiatrist has reviewed the | rarted at a low dose to make sure I have minations, including blood work and a can information sheet regarding the me information with me. I was given the nave the following or other side effects | an Electrocardiogram, may be edication that has been prescribed. ne opportunity to ask questions |
| OCCASIONAL SIDE EF | FECTS: Drowsiness/sleepiness or triion, nausea, decreased appetite, consti | |
| LESS COMMON BUT SI other signs of infections), prolon | ERIOUS: Rapid heartbeat, fainting, nged erection of the penis, yellowing orolonged erection of the clitoris in wo | of skin or eyes, chest pain, rapid |
| Warning: Do not take with an (trazadone | n MAOI or take an MAOI with in 2 w | eeks of stopping Desyrel |
| | may carry the risk of increasing suici However, studies have found that incre with a decrease in suicides | |
| Parent/Guardian contact- Telepl | hone number: | Results of contact: |
| Review of Food and Drug Adm | inistration approval status for this med | dication. |
| Youth's Signature | Psychiatrist's Signature | Date |

Effective Date: 02/10/09

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Form XI.32.A.21

Trazadone

Medical Services

Psychotropic Medication Consent Form Tricyclic Antidepressants

| Youth's name | Date of Birth |
|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr | (Please Print) |
| Name of Medication | Dosage Range |
| | prescribe, and I will take this medication as a part of my mental s medication as prescribed every day, it should help with these |
| | |
| I understand that laboratory examination required. I have been provided an inform My psychiatrist has reviewed the information. | at a low dose to make sure I have as few side effects as possible. ons, including blood work and an Electrocardiogram, may be expressed to sheet regarding the medication that has been prescribed emation with me. I was given the opportunity to ask questions are following or other side effects, I will report them to a doctor or |
| | Ory mouth, constipation, sleepiness, dizziness, weight gain, loss, blurred vision, trouble urinating, fast heart rate |
| LESS COMMON: Nightmares, st | auttering, increased risk of sunburn, increase in breast size in decreased sexual interest, nervousness, shakiness |
| | nausea, trouble urinating, blurred vision, motor tics (fast, ty, rapid speech, feeling "speeded up", decreased need for ash, fainting |
| | SERIOUS: Seizure, very fast or irregular heartbeat, fainting, ag things that are not there), inability to concentrate, severe |
| WARNING: Do not take with MAG | OI's |
| WARNING: Do not take this medicare breastfeeding | cation if you are pregnant, are planning to become pregnant, or |
| | ion suddenly may cause flu-like symptoms |

Form XI.32.A.22 Tricyclic Effective Date: 02/10/09 Page 1 of 2

| | owever, studies have found | sing suicidal thoughts in children, that increased use of antidepressants in |
|---------------------------------|-------------------------------|------------------------------------------------------------------------------|
| Parent/Guardian contact- Teleph | one number: | Results of contact: |
| Review of Food and Drug Admi | nistration approval status fo | r this medication. |
| Youth's Signature | Psychiatrist's S | Signature Date |

WARNING: May worsen glaucoma

Form XI.32.A.22 Tricyclic Effective Date: 02/01/09 Page 2 of 2

Medical Services Psychotropic Medication Consent Form Anti-convulsants (Trileptal)

| Youth's name | Da | ate of Birth |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr. | | (Please Print) |
| Name of Medication | Dosage R | ange |
| * * * | will prescribe, and I will take this me e this medication as prescribed ever | |
| | | |
| | | |
| I understand that laboratory exam required. I have been provided ar My psychiatrist has reviewed the | rted at a low dose to make sure I have inations, including blood work and a information sheet regarding the me information with me. I was given the the following or other side effect | an Electrocardiogram, may be edication that has been prescribed. ne opportunity to ask questions |
| | 'S: Sleepiness, dizziness, clumsines ber of white blood cells, skin rash, d | |
| <u> </u> | US: Lung irritation, worsening of s | seizures, severe skin rashes, loss |
| face), symptoms of low blood so concentrating, feeling sick or unudark urine or pale bowel movement of urination, unusual bruising or leading to the symptoms of the symptoms | An allergic reaction (trouble breat dium (nausea, headache, extreme d sually tired for no reason, loss of ap ents, swelling of legs or feet, greatly bleeding, sore throat or fever, mouth havioral problems, loss of feeling, be other problems with vision | rowsiness or confusion), trouble petite, yellowing of skin or eyes, increased or decreased frequency ulcers, vomiting, skin rash |
| WARNING: Some mood stab | ilizers have been associated with an | increase in suicidal thoughts |
| | one number: | |
| Review of Food and Drug Admir | nistration approval status for this me | dication. |
| Youth's Signature Form XI.32.A.23 Trileptal Effec | Psychiatrist's Signature ctive Date: 02/10/09 | Date Page 1 of 1 |

Medical Services Psychotropic Medication Consent Form Wellbutrin (Bupropion)

| Youth's name | Date | of Birth |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Psychiatrist: Dr | | (Please Print) |
| Name of Medication | Dosage Rang | ge |
| | will prescribe, and I will take this medi e this medication as prescribed every d | |
| | | |
| | | |
| I understand that laboratory exam required. I have been provided an My psychiatrist has reviewed the | rted at a low dose to make sure I have a inations, including blood work and an information sheet regarding the medic information with me. I was given the over the following or other side effects, I | Electrocardiogram, may be cation that has been prescribed. opportunity to ask questions |
| · · · · · · · · · · · · · · · · · · · | S: Irritability, nervousness or restlessr | ness, shakiness, trouble |
| sleeping, dry mouth, constipation, excessive sweating | , headache, decreased appetite and weigh | ght loss, nausea, dizziness, |
| | s or muscle twitching, rash, swelling ar | ound the mouth, ringing in the |
| RARE: Vomiting, seizures, unu swings, hair loss, memory loss, ac | isual excitement, decreased need for sle one, ulcers, flushing, confusion | eep, rapid speech, mood |
| WARNING: Do not take within | in 14 (fourteen) days of an MAOI | |
| - | nts may carry the risk of increasing suic owever, studies have found that increas ith a decrease in suicides | |
| Parent/Guardian contact- Telepho | one number: | Results of contact: |
| Review of Food and Drug Admin | nistration approval status for this medic | ation. |
| Youth's Signature | Psychiatrist's Signature | Date |

Form XI.32.A.24 Wellutrin Effective Date: 02/10/09 Page 1 of 1

Medical Services

Psychotropic Medication Consent Form Antipsychotics

| Youth's name | | Date of Birth |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Psychiatrist: Dr. | | (Please Print) |
| Name of Medication | | Dosage Range |
| Traine of medication | | 2 000,000 |
| V 1 V | • | ake this medication as a part of my mental cribed every day, it should help with these |
| | | |
| | | |
| required. I have been provided My psychiatrist has reviewed regarding the information. If nurse: | ed an information sheet regard the information with me. I we'll have the following or other | work and an Electrocardiogram, may be ling the medication that has been prescribed as given the opportunity to ask questions side effects, I will report them to a doctor o |
| Anxiety, dry mouth, sleepine gain, decreased sexual interedischarge from the breasts, d | ss, constipation, mild trouble us st or ability, changes in mensur rooling, sadness, irritability, no | Y SERIOUS SIDE EFFECTS: urinating, blurred vision, dizziness, weight rual cycle, increase in breast size or ervousness, clinginess, increased risk of sit still, shaking of hands of fingers, |
| LESS COMMON, BUT | POTENTIALLY SERI | OUS: stiffness of tongue, jaw, neck, ular heartbeat; prolonged erection of penis |
| RARE, BUT SERIOUS sometimes by fever, sore throstiffness or lack of movement (GO TO THE EMERGENCY or swallow (GO TO THE EN or excessive sweating, fainting | Decrease in number of blood oat, illness, yellowing of eyes out, very high fever, mental control of the ROOM IF THESE OCCURATES OF THESE OCCURATES. | d cells or damage to the liver (manifested or skin, or skin rash or bruising); extreme fusion, irregular pulse rate, or eye pain); sudden stiffness and inability to breathe SE OCCUR) Feeling hot but not sweating swallowing, seizures, pounding heart beat, |
| WARNING: May worsen | | ic movements that may not stop when the |
| medicine is stopped | | |

Form XI.32.A.25 Anti-Psychotics Effective Date: 08/25/09 Page 1 of 2

WARNING: You should discuss the risks and benefits of continuing this medication with your OB/GYN physician if you are pregnant and/or breastfeeding

| Parent/Guardian contact- Telephone | number: | Results of contact: | |
|------------------------------------|------------------------------------------|---------------------|--|
| | | | |
| | | | |
| Review of Food and Drug Administr | ration approval status for this medicati | on. | |

Form XI.32.A.25 Anti-psychotics Effective Date: 08/25/09 Page 2 of 2