Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Anti-anxiety

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

POSSIBLE SIDE EFFECTS: Sleepiness; sometimes these medications cause the opposite effects than those expected: excitement, irritability, dizziness, anger, aggression, trouble sleeping, nightmares, uncontrollable behavior, memory loss, dry mouth, blurred vision, addiction

WARNING: Stopping this medication suddenly may cause cramps, seizures, depression, hearing and seeing things that are not there, restlessness, trouble sleeping or shakiness

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

Youth's Signature _____ Psychiatrist's Signature _____ Date _____

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Antihistamines

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, unsteadiness, decreased attention or trouble concentrating, dry mouth, blurred vision, constipation, loss of appetite
LESS COMMON: Clumsiness or poor coordination, motor tics (fast repeated movements), unusual muscle movements, irritability, overactivity, shakiness, confusion
VERY RARE BUT SERIOUS: Worsening of asthma or trouble breathing, seizure, uncontrollable behavior, severe muscle stiffness

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

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 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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Tiredness, numbing, cold, or pain in the fingers or toes: dizziness; slow heartbeat, low blood pressure
LESS COMMON: Sadness or irritability, nausea, trouble sleeping or nightmares, diarrhea, skin rash, muscle cramps
SERIOUS: Worsening of asthma or trouble breathing, wheezing, seeing or hearing things that are not there, heart failure
WARNING: Stopping this medication suddenly may cause a dangerous rise in blood pressure

Parent/Guardian contact - Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Buspar

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

POSSIBLE SIDE EFFECTS: Sleepiness, dizziness, nausea, headache, restlessness; sometimes these medications can cause the opposite effects than those expected, uncontrollable behavior, memory loss

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

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

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Slow heartbeat, temporary worsening of tics in Tourette's Disorder, trouble sleeping, ringing in the ears, skin redness and itching under the skin patch, constipation, dry mouth, dizziness
USUAL MILD SIDE EFFECTS: Sleepiness, fatigue, low pressure, agitation
LESS COMMON: Depression, confusion, bed-wetting, muscle cramps, itching, runny nose
VERY RARE BUT SERIOUS: Fainting, irregular heartbeat, trouble breathing, kidney failure; decreased frequency of urination, swelling of body, sudden headaches with nausea and vomiting
WARNING: Stopping this medication suddenly may cause a dangerous rise in blood pressure; temporary worsening of behavioral problems or tics; nervousness or anxiety; rapid or irregular heartbeat; chest pain; headache; stomach cramps (nausea, vomiting), trouble sleeping

Parent/Guardian- contact. Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Cymbalta

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Nausea, sleepiness, headaches, dry mouth, dizziness, trouble sleeping, constipation, tiredness
LESS COMMON: Diarrhea, loss of appetite, sore throat, runny nose, weakness, sweating, vomiting, decreased sex drive, shakiness, blurred vision, anxiety, agitation, hot flashes, yawning, coughing, muscle spasms, taste changes
RARE: Anxiety attacks, restlessness, ear pain, acne, sensitivity to the sun, high blood pressure
RARE BUT SERIOUS: Extreme feelings of happiness or depression, seeing or hearing things that are not there, chest palpitations, aggressiveness, trouble urinating, heart failure, very fast heart rate

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: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Anticonvulsants: Depakote

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Upset stomach, increased appetite, weight gain, thinning hair, tremor (shakiness), drowsiness, sleepiness, increased facial or body hair, irregular menstrual periods, increased aggression, increased irritability or depression, shakiness, vision problems
VERY RARE BUT SERIOUS: Liver failure, inflammation of the pancreas (severe abdominal pain), enlargement of ovaries, severe acne, problems breathing, infection
POSSIBLY DANGEROUS: Feeling weak or unusually tired, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of legs, feet or face; greatly increased or decreased frequency of urination; unusual bruising and bleeding; sore throat; mouth ulcers; vomiting; persistent stomachache; skin rash, seizure, severe behavioral problems; mental confusion

WARNING: May cause birth defects if given to pregnant women

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

Parent/Guardian contact - Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Effexor [venlafaxine]

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Anxiety/nervousness, nausea, sleepiness, insomnia, decreased appetite, weight loss, weakness
LESS FREQUENT: Yawning, blurred vision, dry mouth, dizziness, constipation, excessive sweating, lack of energy, trouble with sexual functioning
LESS COMMON BUT MORE SERIOUS: Increased blood pressure, seizures

WARNING: Do not give MAOI's, stopping 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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

Youth's Signature _____ Psychiatrist's Signature _____ Date _____

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Klonopin [clonazepam]

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Difficulty with balance, drowsiness or sleepiness, irritation, excitement, increased anger or aggression, trouble sleeping or nightmares, memory loss
SERIOUS: Uncontrollable behavior, depression if combined with alcohol, may lead to severe sleepiness, unconsciousness or **DEATH**

WARNING: Stopping this medication suddenly may cause; Cramps, seizures, depression, seeing or hearing things that are not there, restlessness, trouble sleeping or shakiness

WARNING: May be habit forming

Parent/Guardian contact-Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Lamictal

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, headache, double vision, unsteadiness, blurred vision, nausea, anxiety or nervousness, agitation or mania, dry mouth, cough, tiredness
VERY RARE BUT SERIOUS: Vomiting, change in color of urine or frequency of urination, severe skin rash
POSSIBLY DANGEROUS: Feeling weak or sick or unusually tired, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of legs, feet, or face, greatly increased or decreased frequency of urination, unusual bruising or bleeding, sore throat, mouth ulcers, vomiting, persistent stomachache, seizure, severe behavioral problems, mental confusion

WARNING: Rarely, a serious, sometimes fatal skin rash may occur while using this medication. These rashes are more common in children under 16 (sixteen). Immediately notify your doctor if you develop any type of rash.

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 Administration approval status for this medication.

Youth's Signature _____ Psychiatrist's Signature _____ Date _____

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Lithium

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Weight gain, stomachache, diarrhea, nausea, vomiting, mild increased thirst, increased frequency of urination, mild shakiness of hands, tiredness, headache, dizziness
OCCASIONAL: Low thyroid function or goiter (enlarged thyroid) tiredness, feeling cold, weight gain, dry skin, coarser hair, decreased school performance, acne, skin rash, hair loss, bed-wetting, change in blood sugar, metallic taste in mouth, irritability
LESS COMMON BUT MORE SERIOUS—CALL THE DOCTOR IF: Persistent vomiting or diarrhea, weakness, lack of coordination, unsteadiness when standing or walking, severe shaking extreme sleepiness or tiredness, severe dizziness, trouble speaking or slurred speech, confusion
SEVERE TOXIC EFFECTS OF TOO MUCH LITHIUM: Irregular heartbeat, fainting, staggering, blurred vision, ringing or buzzing sound, inability to urinate, muscle twitches, high fever, seizure, unconsciousness **WARNING-** dehydration can lead to the symptoms stated above **AVOID** drinking large amounts of coffee, tea, cola, or excessive sweating, which can cause dehydration. Taking NSAIDs may cause an increase in Lithium levels.

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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Neurontin

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, itchy runny nose, unsteadiness, rapid involuntary movements of eyes, feeling tired, double vision, tremor, fever in children, nausea, weight increase (in children)
BEHAVIORAL OR EMOTIONAL: Worsening of behavioral problems, temper tantrums, increased anger and/or aggression, irritability

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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Lithium

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Weight gain, stomachache, diarrhea, nausea, vomiting, mild increased thirst, increased frequency of urination, mild shakiness of hands, tiredness, headache, dizziness
OCCASIONAL: Low thyroid function or goiter (enlarged thyroid) tiredness, feeling cold, weight gain, dry skin, coarser hair, decreased school performance, acne, skin rash, hair loss, bed-wetting, change in blood sugar, metallic taste in mouth, irritability
LESS COMMON BUT MORE SERIOUS—CALL THE DOCTOR IF: Persistent vomiting or diarrhea, weakness, lack of coordination, unsteadiness when standing or walking, severe shaking extreme sleepiness or tiredness, severe dizziness, trouble speaking or slurred speech, confusion
SEVERE TOXIC EFFECTS OF TOO MUCH LITHIUM: Irregular heartbeat, fainting, staggering, blurred vision, ringing or buzzing sound, inability to urinate, muscle twitches, high fever, seizure, unconsciousness **WARNING-** dehydration can lead to the symptoms stated above **AVOID** drinking large amounts of coffee, tea, cola, or excessive sweating, which can cause dehydration. Taking NSAIDs may cause an increase in Lithium levels.

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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Neurontin

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, itchy runny nose, unsteadiness, rapid involuntary movements of eyes, feeling tired, double vision, tremor, fever in children, nausea, weight increase (in children)
BEHAVIORAL OR EMOTIONAL: Worsening of behavioral problems, temper tantrums, increased anger and/or aggression, irritability

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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Remeron

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, weight gain, nausea, increased appetite, dry mouth
OCCASIONAL: Dizziness, constipation, lack of energy, tiredness, frequent urination
LESS COMMON: Vomiting or diarrhea, confusion, seizure, infection, yellowing of skin or eyes, dark urine or pale colored bowel movements, increased irritability , abnormal dreams
WARNING: Avoid taking with MAOI's

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 decreased in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Antipsychotics

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON AND USUAL, BUT NOT USUALLY SERIOUS SIDE EFFECTS: Anxiety, dry mouth, sleepiness, constipation, mild trouble urinating, blurred vision, dizziness, weight gain, decreased sexual interest or ability, changes in menstrual cycle, increase in breast size or discharge from the breasts, drooling, sadness, irritability, nervousness, clinginess, increased risk of sunburn, itchy skin or skin rash, restlessness or inability to sit still, shaking of hands of fingers,
RARE: Not being able to control face, arm or leg movements
RARE BUT SERIOUS: Feeling hot but not sweating or excessive sweating, fainting, trouble breathing, trouble swallowing, seizures, pounding heart beat, high fever with rigid muscles, trouble breathing, diabetes or high blood sugar
WARNING: May worsen glaucoma; may cause rhythmic movements that may not stop when the medicine is stopped
WARNING: May cause agranulocytosis
WARNING: In light of ACOG guidelines you seriously consider the use of this medication. 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:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
SSRIs

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Nausea, upset stomach, diarrhea, headache, anxiety or nervousness, insomnia, restlessness, dry mouth, dizziness, tremor or shakiness, excessive sweating, lack or interest, decreased sexual interest or trouble with sexual functioning, weight loss, weight gain, flu-like symptoms, yawning
LESS COMMON BUT MORE SERIOUS: Increased activity, rapid speech, feeling "speeded up", decreased need for sleep, being very excited or irritability (cranky), easy bruising, bleeding
SERIOUS: Seizure, heatstroke, stiffness, high fever, confusion, tremors (shaking), severe rash

Warning: Stopping this medication suddenly may cause; flu-like symptoms

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: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Stimulants

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Lack of appetite and weight loss, nausea, insomnia, headaches, stomachaches, nervousness, crying, emotional sensitivity
LESS COMMON: Irritability (crankiness), rebound (hyperactivity as medicine wears off), slowing of growth, nervous habits, stuttering, motor or vocal tics (fast repeated movements or sounds), staring into space, fast heart beat, increased blood pressure
RARE BUT SERIOUS: Muscle cramps or twitches, sadness that lasts more than a few days, auditory, visual or tactile hallucinations (hearing, seeing or feeling things that are not there) any behavior that is very unusual for your child, yellowing of the skin or eyes, stroke, sudden death in children with heart problems, seizures, chest tightness or chest pain, pounding or irregular heart beat, sweating, trembling or shaking

Warning: Do not take within 14 (fourteen) days of an MAOI

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

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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Strattera (Atomoxetine)

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness or trouble sleeping, nausea, loss of appetite, upper abdominal pain, dry mouth
LESS COMMON: Indigestion, headache, constipation, facial tics,
RARE: Growth problems, diarrhea, abnormal dreams, weight loss, crying, mood swings, sudden attack of low blood pressure, aggressive behavior
RARE BUT SERIOUS: Possible liver problems (yellowing of the skin or eyes) seeing or hearing things that are not there, chest pain, racing heart

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

Warning: Do not take with MAOI's, avoid if you have narrow angle glaucoma

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

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Symbyax

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON AND USUAL, BUT NOT USUALLY SERIOUS SIDE EFFECTS: Anxiety, dry mouth, sleepiness, constipation, mild trouble urinating, blurred vision, dizziness, weight gain, loss of appetite and weight loss, decreased sexual interest or ability, changes in menstrual cycle, increase in breast size or discharge from the breasts, drooling, sadness, irritability, nervousness, clinginess, increased of sunburn, itchy skin or skin rash, restlessness or inability to sit still, shaking of hands of fingers, trouble urinating, fast heart rate, feeling weak, trouble concentrating
LESS COMMON: Nightmares, stuttering, increased risk of sunburn, nervousness, shakiness, high cholesterol or triglycerides
LESS COMMON BUT MORE SERIOUS: Increased activity, rapid speech, feeling "speeded up", decreased need for sleep, being very excited or irritability (cranky), easy bruising, bleeding
RARE: Fainting, high or low blood pressure, not being able to control face, arm or leg movements
RARE BUT SERIOUS: Feeling hot but not sweating or excessive sweating, fainting, trouble breathing, trouble swallowing, seizures, pounding heart beat, high fever with rigid muscles, diabetes or high blood sugar, severe rash, abnormal bleeding, trouble thinking clearly, seizures

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: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Tegretol

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, clumsiness or decreased coordination, nausea, mild decrease in white blood cells,
LESS COMMON: Aching joints or muscles, constipation, diarrhea, dry mouth, headache, increased sweating, irritation or soreness of tongue or mouth, loss of appetite, loss of hair, sexual problems in males, stomach pain, increased sensitivity to sunlight, motor or vocal tics, anxiety or nervousness, behavioral changes, skin rash or itching
VERY RARE BUT SERIOUS: Decrease in number of blood cells, worsening of seizures, severe skin rash , low sodium in the blood, congestive heart failure
POSSIBLY DANGEROUS: Feeling weak or unusually tired for no reason, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of ;legs, feet or face; greatly increased or decreased frequency of urination; unusual bruising and bleeding; sore throat/fever; mouth ulcers; vomiting; persistent stomachache; skin rash especially with fever, seizure, severe behavioral problems, depression, hearing voices or seeing things that are not there, blurred or double vision

Warning: May make birth control pills less effective

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 number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Topamax

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, slowed movements, skin feeling like "pins and needles, fatigue, nausea, memory problems and trouble concentrating, tremors (shakiness), weight loss and decreased appetite
LESS COMMON: Back pain, chest pain, constipation, indigestion, hot flashes, increased sweating, leg pain, taste changes, irritability, nervousness, vomiting
POSSIBLY DANGEROUS: Clumsiness or poor coordination, bloody or cloudy urine, unexplained fever (chills and/or sore throat), sharp back pain, blurred or double vision or eye pain, trouble breathing or rapid breathing, blood clots, fainting, depression, high blood sugar, increased temperature with decreased sweating

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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Desyrel (Trazadone)

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Drowsiness/sleepiness or trouble sleeping, dry mouth, dizziness, headache, blurred vision, nausea, decreased appetite, constipation, more frequent erections [boys], increased interest in sex {girls}
LESS COMMON BUT SERIOUS: Rapid heartbeat, fainting, vomiting, fever (sore throat, other signs of infections), prolonged erection of the penis, yellowing of skin or eyes, chest pain, rapid heart rate, shortness of breath, prolonged erection of the clitoris in women , easy bruising or bleeding

Warning: Do not take with an MAOI or take an MAOI with in 2 weeks of stopping Desyrel (trazadone

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: _____ Results of contact:

_____

Review of Food and Drug Administration approval status for this medication.

Youth's Signature _____ Psychiatrist's Signature _____ Date _____

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Tricyclic Antidepressants

_____ _____
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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Dry mouth, constipation, sleepiness, dizziness, weight gain, loss of appetite and weight loss, irritability, blurred vision, trouble urinating, fast heart rate
LESS COMMON: Nightmares, stuttering, increased risk of sunburn, increase in breast size in boys or girls, nipple discharge in girls, decreased sexual interest, nervousness, shakiness
RARE: High or low blood pressure, nausea, trouble urinating, blurred vision, motor tics (fast, repeated movements), increased activity, rapid speech, feeling "speeded up", decreased need for sleep, being very excited or irritable, rash , fainting
RARE BUT POTENTIALLY SERIOUS: Seizure, very fast or irregular heartbeat, fainting, hallucinations (hearing voices or seeing things that are not there), inability to concentrate, severe change in behavior, liver problems
WARNING: Do not take with MAOI's
WARNING: Do not take this medication if you are pregnant, are planning to become pregnant, or are breastfeeding
WARNING: Stopping this medication suddenly may cause flu-like symptoms

WARNING: May worsen glaucoma

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: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

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

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, clumsiness or decreased coordination, nausea, mild decrease in the number of white blood cells, skin rash, diarrhea, constipation, decreased appetite, headache, dry mouth
VERY RARE BUT SERIOUS: Lung irritation, worsening of seizures, severe skin rashes, loss of sodium from the blood
POSSIBLY DANGEROUS: An allergic reaction (trouble breathing, swelling of lips, tongue or face) , symptoms of low blood sodium (nausea, headache, extreme drowsiness or confusion), trouble concentrating, feeling sick or unusually tired for no reason, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of legs or feet, greatly increased or decreased frequency of urination, unusual bruising or bleeding, sore throat or fever, mouth ulcers, vomiting, skin rash (especially with fever), severe behavioral problems, loss of feeling, back and forth movements of the eyes, blurred or double vision or other problems with vision

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

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Wellbutrin (Bupropion)

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Irritability, nervousness or restlessness, shakiness, trouble sleeping, dry mouth, constipation, headache, decreased appetite and weight loss, nausea, dizziness, excessive sweating
LESS COMMON: Motor tics or muscle twitching, rash, swelling around the mouth, ringing in the ears, increased blood pressure, fast heart beat, blurry vision,
RARE: Vomiting, seizures, unusual excitement, decreased need for sleep, rapid speech, mood swings, hair loss, memory loss, acne, ulcers, flushing, confusion

WARNING: Do not take within 14 (fourteen) days of an MAOI

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: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____

Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Antipsychotics

_____ _____

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 know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON AND USUAL, BUT NOT USUALLY SERIOUS SIDE EFFECTS: Anxiety, dry mouth, sleepiness, constipation, mild trouble urinating, blurred vision, dizziness, weight gain, decreased sexual interest or ability, changes in menstrual cycle, increase in breast size or discharge from the breasts, drooling, sadness, irritability, nervousness, clinginess, increased risk of sunburn, itchy skin or skin rash, restlessness or inability to sit still, shaking of hands of fingers,
LESS COMMON, BUT POTENTIALLY SERIOUS: stiffness of tongue, jaw, neck, back, or legs; overheating or heatstroke, seizure; very irregular heartbeat; prolonged erection of penis
RARE, BUT SERIOUS: Decrease in number of blood cells or damage to the liver (manifested sometimes by fever, sore throat, illness, yellowing of eyes or skin, or skin rash or bruising); extreme stiffness or lack of movement, very high fever, mental confusion, irregular pulse rate, or eye pain (GO TO THE EMERGENCY ROOM IF THESE OCCUR); sudden stiffness and inability to breathe or swallow (GO TO THE EMERGENCY ROOM IF THESE OCCUR)Feeling hot but not sweating or excessive sweating, fainting, trouble breathing, trouble swallowing, seizures, pounding heart beat, high fever with rigid muscles, trouble breathing, diabetes or high blood sugar
WARNING: May worsen glaucoma; may cause rhythmic movements that may not stop when the medicine is stopped

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:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date