Hillcrest Educational Centers

Residential Treatment Centers

PO Box 4699, Pittsfield, MA 01201

Form: CONSENT FOR NEW MEDICATION

Date: ____/____/_200___ HEC campus: _____

To (Name): _____

Legal Guardian of (Student's Name): _____

Proposed Medication Order(s):

Dosage range for this medication will be:

Reason for Medication Order(s):

Possible Side Effects to Watch For/Monitor:

Physician Ordering Medication: _____
Specialty: _____

Verbal Consent Obtained From (name): _____

Relationship to student: _____

By Nurse: _____ Date: ___/____/200__ Time: _____ AM ___ PM ___

Witness 1 signature: _____

Dear Mr. or Ms. _____
It is our understanding that on __/___/200___ you gave us verbal consent to treat your son/daughter, as witnessed by the above staff. Consistent with your approval, we have proceeded with the medication order identified above. *If there has been a misunderstanding regarding your approval, please contact us immediately at (413)_____.*
If our understanding is correct and you have approved this medication order, please sign this form (below) **and return it in the self-addressed, envelope. Thank you.**

Signature of Legal Guardian: _____ Date: ___/___/200__

8/05