FLORIDA DEPARTMENT OF JUVENILE JUSTICE

ACKNOWLEDGMENT OF RECEIPT OF CLINICAL PSYCHOTROPIC PROGRESS NOTE OR PRACTITIONER FORM (PARENTAL CONSENT FOR PSYCHOTROPIC MEDICATION)

NAME OF YOUTH: _____ **DOB:** _____ **DJJID#:** _____

Date Mailed to Parent_____ Facility Name: _____

Parent or Guardian Name
Mailing Address
City, State, Zip Code

Dear Mr./Mrs. _____:

Your child saw the practitioner_____ on _____.
As part of your child's treatment, the practitioner has recommended that your child be prescribed the medication(s) listed on the attached form entitled Clinical Psychotropic Progress Note (CPPN) or the attached practitioner form that was completed on the day your child was seen.

This letter has been sent to you to:

- ❑ Confirm your oral consent to initiate this treatment, which you gave on _____.

- ❑ Obtain your written consent to begin this treatment, as we were unable to contact you by other means. **It is important for you to contact us and return this form as soon as possible for treatment to begin**. We cannot begin the recommended treatment without your consent.

If you have questions or wish to speak to staff about these medications, please call the following number and ask to speak to the contact person listed below:

Phone Number ( ) _____ Contact Person_____

PLEASE SIGN YOUR NAME AND DATE THE SIGNATURE ON THE LINES AT THE END OF THIS FORM TO ACKNOWLEDGE YOUR RECEIPT OF THE ATTACHED INFORMATION AND TO PROVIDE US WITH YOUR CONSENTFOR THE PSYCHOTROPIC MEDICATION LISTED ON THE ATTACHED CPPN OR PRACTITIONER FORM. AFTER SIGNING, PLEASE MAIL THIS LETTER BACK TO US AT:

_____

_____

_____

_____ _____
Parent/Guardian Signature **Date Signed**

(The attached Clinical Psychotropic Progress Note (CPPN) form or practitioner form that explains the medication is for you to keep. You do not need to send it back to us.)