FLORIDA DEPARTMENT OF JUVENILE JUSTICE

PARENTAL NOTIFICATION OF HEALTH-RELATED CARE: MEDICATION MANAGEMENT

(Not for Psychotropic Medications)

NAME OF YOUTH: _____ **DATE OF BIRTH:** _____

FACILITY NAME: _____ **DJJID#:** _____ **DATE:** _____

PARENT/GUARDIAN NAME AND ADDRESS: _____

_____

DJJ FACILITY NAME AND ADDRESS: _____

_____

Dear:

Our records indicate that you are the parent(s) or guardian who has authority over health care for the above named youth. The purpose of this form is to notify you that a licensed health care practitioner has recommended the following medication or medication changes.

The following medication has been ordered, started or changed:

Medication: _____ _____times per day, by _____for _____days
(route)

Purpose: _____

Possible Side Effects:_____

_____ _____
Signature of Health Care Provider Printed Name of Person Completing Form

If you have any concerns about the above information or do not want your child to receive this medication/treatment; notify the DJJ facility at the phone number indicated.

Phone Number: _____

Person to Contact: _____

☐ **TO THE PARENT/GUARDIAN: IF THIS BOX IS CHECKED, THIS MEANS THAT YOU HAVE BEEN NOTIFIED BY PHONE OF THE HEALTH CARE TREATMENT ABOVE. WE NEED YOU TO GIVE YOUR CONSENT IN WRITING AND SEND THIS FORM BACK TO US AT THE FACILITY ADDRESS LISTED ABOVE. YOUR SIGNATURE INDICATES THAT YOU GIVE YOUR PERMISSION FOR US TO ADMINISTER THIS MEDICATION.**

_____ _____
Parent/Guardian Signature Date

** Copy of Notification to be filed in Individual Health Care Record.