PSYCHOTROPIC MEDICATION DOCUMENTATION

State Form 49966 (R / 5-09) / BCC 0059

(This form may be used for information documented on facility's forms.)

NAME OF CHILD / ADMISSION DATE	NAME OF PSYCHOTROPIC MEDICATION	REASON MEDICATION IS CONTINUED, CHANGED OR DISCONTINUED	DATE CHILD WAS SEEN BY PHYSICIAN
			Date *(month, day, year)* *Check one:* ☐ Child Seen ☐ Reports Evaluated Signature of Physician
			Date *(month, day, year)* *Check one:* ☐ Child Seen ☐ Reports Evaluated Signature of Physician
			Date *(month, day, year)* *Check one:* ☐ Child Seen ☐ Reports Evaluated Signature of Physician
			Date *(month, day, year)* *Check one:* ☐ Child Seen ☐ Reports Evaluated Signature of Physician

1. **Psychotropic medication must be prescribed by licensed physician who has responsibility for the diagnosis, treatment, and therapeutic planning for the child.**
2. **Child caring institution shall obtain from prescribing physician, a written report every thirty (30) days stating why medication is being continued, discontinued, or changed and recommended changes in treatment goal and planning.**
3. **Physician's report based on review of reports by staff and / or actual observation of child.**
4. **Physician must have actual observation of child every ninety (90) days.**