"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

San Mateo County Health System
Behavioral Health and Recovery Services

THERAPEUTIC DAY SCHOOL MEDICATION SUPERVISION CONSENT FORM

Youth's Name _____ **MH#** _____

Address _____

_____

Parent or Legal Guardian _____

Home Phone _____ *Work #* _____ *Cell #* _____

Allergies

Food _____

Medicine _____

Other _____

Daily Medication **Yes** _____ **No** _____

If Yes, Drug _____ **Dosage** _____ **Time** _____**AM** _____**PM**

Prescribing MD _____ Phone_____

Drug _____ **Dosage** _____ **Time** _____**AM** _____**PM**

Prescribing MD _____ Phone_____

Drug _____ **Dosage** _____ **Time** _____**AM** _____**PM**

Prescribing MD _____ Phone_____

Drug _____ **Dosage** _____ **Time** _____**AM** _____**PM**

Prescribing MD _____ Phone_____

Signature of Prescribing MD _____

List any medical condition limiting the youth from participating in any activity.

_____

_____

I, the undersigned, authorize San Mateo County Day Treatment Services staff members to supervise _____ (youth) with prescribed medications.

_____ _____

Signature of Parent/Legal Guardian **Date**