"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.

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____

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

____ ___________________

Signature of Parent/Legal Guardian **Date**