



Department of Children and Family Services
 Health Care Unit, Rm 119 E
 3955 Euclid Avenue, Cleveland, OH 44115
 Phone: (216) 881-4712
 *Fax: (216) 431-4109 *
 Afterhours Authorizations: (216) 696-KIDS
 Medicaid Hotline: (216) 432-3389

Request to Administer Psychotropic Medication

Note : Please submit information on side effects and drug interactions with this request.

Please type or print CLEARLY

Child's Name: (first, mi, last)	dob:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Prescribing Physician Information

Name:	Practice/Facility Name:
Address:	City/St/Zip:
Phone #: ()	Fax #: ()

Placement/Substitute Caregiver Information

Placement: (Foster, Residential, etc.)	Placement/Caregiver's Name:
Address:	City/St/Zip:
Phone #: ()	Fax #: ()

Rx Information

Name of Rx	Dosage / Frequency	(Check as applicable)
1.		<input type="checkbox"/> Begin <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Discontinue
2.		<input type="checkbox"/> Begin <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Discontinue
3.		<input type="checkbox"/> Begin <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Discontinue
Indications for Use:		
List other supportive measures being taken:		
Pursuant to S.B. 262 and O.R.C. 3313.713 - "Administration of Prescribed Medication in School", while at school, can the child be dispensed this medication based on the policy adopted by the school's Board of Education? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Please list all other medications that the child is presently taking:		

Signature of Prescribing Physician _____

Date _____