



Consent to Use Medication as a Behavioral Intervention or for a Clinical Diagnosis

_____ (participant) has the following medication(s) prescribed for help with behavioral control or a clinically recognized diagnosis for a medical condition or mental disorder. This medication is administered by ABLED, Inc. staff, who are also responsible for taking this participant to the prescribing physician on a regular basis to review the medication(s) and the effectiveness of the identified behaviors. This document outlines the medications prescribed, the clinical diagnosis, and the name of the doctor who prescribed the medication. Possible side effects are available on the MAR under “Drug Details”.

Medication and Dosage	Reason Prescribed or Clinical Diagnosis	Prescribing Physician

I, _____, guardian of _____ (participant), have reviewed the information outlined above. I give my consent to continue the use of the medications listed. I understand that I may request more information and may speak with an ABLED, Inc. representative or the prescribing physician to obtain that information. I understand that I may withdraw my consent for the use of this medication at any time.

Participant:

Date:

Legal Guardian: (If applicable)

Date:

ABLED, Inc. Representative:

Date: