CONSENT FOR USE OF PSYCHOTROPIC MEDICATIONS

I, X _____ (parent/legal guardian of) _____

have been informed by Dr. Rubio about the nature and purpose of the treatment with CLONIDINE, its risks and benefits.

Additionally, I/we have been given more explanation by way of medication informational sheet/s describing possible risks or complications of the administration of the medication being recommended. Also, I/we have been informed that I/my child will be referred for any necessary medical work-up, whenever indicated.

I/We have sufficient opportunity to discuss my/my child's condition and my/his/her treatment with Dr. Rubio, and my questions have been answered to my satisfaction. I/We believe that I/we have adequate knowledge upon which to base an informed consent to the proposed treatment.

X _____ _____

Signature of Patient (Parent/Guardian) **Signature of Witness**

X _____ _____

Date **Date**