

**CONSENT FOR USE OF PSYCHOTROPIC MEDICATIONS**

I, X \_\_\_\_\_ (parent/legal guardian of) \_\_\_\_\_  
have been informed by Dr. Pueblo about the nature and purpose of the  
treatment with Risperidone, 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. Pueblo, 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