

Clerk stamps date here when form is filed.

You may use this form to give the court input on the request for an order for medication for the youth.

You do not *have to* use this form if you do not want to. There are other ways to give input to the court. You may:

- Send a letter to the judge
- Speak to the judge at the hearing, or
- Ask your lawyer or the child's social worker, probation officer, or CASA to tell the judge how you feel.

You may add pages to this form if you need more space for your answers. Please put the child's name and the number of the question you are answering on each extra page.

Child's name:

_____ (first) (middle) (last)

1 Your name: _____ (first) (middle) (last)

2 Your relationship to the child: Caregiver CASA Indian Tribe Parent Other (explain): _____

3 How long have you known the child? _____ (years) (months) (days)

4 How long has the child lived in your home or facility? _____ (years) (months) (days)

Child's Behavior

5 How does the child act at home? Don't know
Describe here: _____

6 How does the child act at school? Don't know
Describe here: _____

Fill in court name and street address:

Tribal Court of: _____

Fill in child's name and date of birth:

Child's Name: _____
Date of Birth: _____

Court fills in case number when form is filed.

Case Number: _____

Case Number: _____

Child's name: _____

7 How does the child interact with friends and peers? Don't know
Describe here: _____

8 How does the child interact with adults? Don't know
Describe here: _____

9 How does the child sleep? Don't know
Describe how well the child sleeps and about how many hours each day: _____

Describe the Child's Treatment Now

10 List any other treatment the child is doing now:
 None Individual talk therapy Family therapy
 Group talk therapy Counseling at school Art or play therapy
 Cognitive Behavioral Therapy (CBT or practicing behaviors)
 Other (list any other treatment here): _____

11 List all the medicines the child takes regularly now. Don't know

Name of medicine: _____ Dose (if you know): _____
Name of medicine: _____ Dose (if you know): _____
Name of medicine: _____ Dose (if you know): _____
 Other medicines (list here): _____

12 Did you meet with the doctor who prescribed the psychotropic medicine? Yes No

If Yes:
a. Did the doctor explain the medicine's expected benefits, possible side effects, and provide other information about the medicine? Yes No
b. Did you give the doctor information about the child? Yes No
c. Do you agree with use of the medication? Yes No Not sure



Case Number: _____

Child's name: _____

13 Follow-up and Maintenance

- a. Do you know about the child's follow-up plan with this doctor? Yes No
- b. Do you know how to schedule follow-up appointments with this doctor? Yes No
- c. Do you know how and where to get the medicine the doctor prescribed? Yes No
- d. Do you know how to make sure the child gets to the follow-up appointments? Yes No
- e. Do you know how the child is supposed to take this medicine? Yes No
- f. Do you know who is in charge of making sure s/he takes the medicine correctly?
If Yes, describe here: _____ Yes No
- g. Do you know what to do if the child has a bad reaction to the medicine? Yes No

14 List below anything else you want the judge to know.

Fill out questions 15–23 ONLY if the child is taking psychotropic medicine now

If the child is not taking this/any psychotropic medicine now, skip to question 24.

- 15** Does the medicine affect the child's school or ability to learn? Yes No Don't know
If Yes, describe here: _____

- 16** Does the medicine affect the child's ability to concentrate? Yes No Don't know
If Yes, describe here: _____

- 17** Does the child have reasonable energy levels throughout the day? Yes No Don't know
If No, describe here: _____

- 18** Does the medicine affect the child's participation in hobbies or after-school activities?
 Yes No Don't know
If Yes, describe here: _____



Case Number: _____

Child's name: _____

19 Is it easy to get the child to take the medicine? Yes No Don't know
If No, describe what it's like: _____

20 Does anyone talk to the child about how he or she feels when he or she is on this medicine?
 Yes No Don't know
If Yes, explain who and how often: _____

21 Has the child's weight changed with this medicine? Yes No Don't know
If Yes, check one: lost weight gained weight How many pounds? _____


22 List any other side effects from the medicine:
 Headache Constipation Confusion Feel dizzy
 Problems sleeping Feeling very sleepy Nausea
 Other (list any other side effects here): _____

23 List any benefits you have noticed from the child's taking this medicine:

24 Check here if you are going to add extra pages to this form. Any say how many pages: _____

Date: _____

Type or print your name

 _____
Caregiver signs here