Sandra G. Rubin, MD
5480 Wisconsin Avenue, Suite 228
Chevy Chase, MD 20815
Phone: 301-654-0285
Fax: 301-652-3282

CONSENT TO USE OF MEDICATION

Name of Patient: _____

MR #: _____

I acknowledge that Dr. Rubin has discussed the use of medication (_____) with me for the treatment of my child, _____. Alternative treatments and no treatment interventions were also discussed. I have been advised of potential short-term and long-term positive and adverse side effects of the above drug and knowing those, I hereby give my informed consent for this pharmacological treatment.

_____ _____

Parent or Legal Guardian Witness

_____

Date

MB/py

mbconsen.psy