JV-219 Statement About Medicine Prescribed

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.

Fill in court name and street address:

Superior Court of California, County of

Child's name: _____
(first) *(middle)* *(last)*

Fill in child's name and date of birth:

Child's Name:

Date of Birth:

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

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

Court fills in case number when form is filed.

Case Number:

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)*

☐ The child does not live with me.

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: _____

Child's name: _____ **Case Number:**

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, and 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

Child's name: _____

Case Number:

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? ☐ Yes ☐ No

If Yes, describe here: _____

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: _____

_____

_____

Child's name: _____

Case Number:

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. And say how many pages: _____

Date:

_____ ▶ _____

Type or print your name *Sign your name*

For your protection and privacy, please press the Clear This Form button after you have printed the form.

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