Partnership Plan For Wellness  
Children’s Services  
(Physicians and RNs)

This plan is to describe the treatment goals and responsibilities for my child and family. My (foster) child’s psychiatrist, my (foster) child, and I will work on this plan together and review these goals at least every 6 – 12 months.

My Child’s/Family Strengths:

We will collaborate with our psychiatrist to minimize or eliminate symptoms and to prevent or minimize medication side effects so that my child may better live like others the same age.

Specify goals for my child’s treatment may include (√ all appropriate boxes):

☐ To feel well 
☐ To enjoy a better social life 
☐ To achieve a healthy living environment at home 
☐ To do well in school 
☐ To gain skills that promote independence 
☐ To avoid the need for hospitalization 
☐ To fully participate in sports/arts/community activities

Additional goals for my child’s treatment:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Strategies we will use to achieve Goals –

☐ We will discuss my child’s behavioral challenges and conditions.
☐ We will understand and be able to describe at each visit, the potential benefits, risks, and side effects of my child’s medications.
☐ We will understand treatment options, including other medications and alternatives to medications and discuss them with the psychiatrist at each visit.
☐ We will identify and discuss different steps to improve my child’s health at each visit so that my child’s treatment is safe, specific, and effective.
☐ We will recognize and discuss at each visit, side effects of my child’s medications or other concerns my child or I might have regarding my child’s treatment.

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☐ My child will take any medication as prescribed and report to the psychiatrist at each visit any difficulty in doing so.
☐ We both will attend all of our appointments with the psychiatrist.
☐ My child and/or I will attend monthly medication support group.
☐ My child and I will discuss with the psychiatrist whenever my child engages in self-harmful activities and discuss strategies to prevent such activities.
☐ My child and I will identify 3 stressors or events that trigger a crisis and discuss with the psychiatrist at each visit, stressors as they come up.

I can help my child’s treatment by developing a trusting relationship with the psychiatrist. It is important for both my child and me to feel comfortable talking with my child’s doctor about changes in symptoms, concerns about medications, and any side effects that my child experiences.

My signature and my child’s signature on this plan indicate our participation in discussion about its contents.

___________________________________________        _____________________________________
Parent/Foster Parent’s Signature*        Date Psychiatrist Signature                 Date

___________________________________________        Date
Child/Adolescent’s Signature        Date

On __________, the parent was offered and: ☐ received ☐ declined a copy of Partnership Plan.

*If no signature, see progress note dated: ________________________________

Goals for this treatment added or changed after signature above: (Please date additions or changes.):

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

My signature and my child’s signature on this plan indicate our participation in discussion about these additions or changes

___________________________________________        _____________________________________
Parent/Foster Parent’s Signature*        Date Psychiatrist Signature                 Date

___________________________________________        Date
Child/Adolescent’s Signature        Date

On __________, the parent was offered and: ☐ received ☐ declined a copy of Partnership Plan.

*If no signature, see progress note dated: ________________________________