PSYCHOTROPIC PROVIDER AUTHORIZATION

I am a health care provider for the student identified below and I have prescribed psychotropic drugs for the student. I understand that the student plans to attend Boston University Tanglewood Institute (BUTI), an unstructured, unsupervised, and demanding residential academic environment. I understand that BUTI will administer the prescription medication to the student, but that it is the responsibility of the student to obtain and take medication. BUTI will not remind or compel students to take prescription medication. In my judgment, the student is able to participate in the BUTI program.

Student Name: _____ DOB: _____

Clinician Name and Degree (printed): _____

Clinician Address: _____

Clinician Phone: _____

Clinician Signature: _____ Date: _____

This form is to be completed by the student's physical or mental health clinician who prescribes their psychotropic medication, and mailed directly to:

Coordinator of Health Services
Boston University Tanglewood Institute
45 West Street
Lenox, MA 01240