MEDICATION CONSENT

My provider has educated me regarding the medication that has been prescribed to ☐ me, ☐ my child, or ☐ a person for whom I am the legal guardian and I consent to the administration of this medication. I have been informed of the purpose for which this medication is prescribed as well as the most common side effects of this medication. I am also responsible for checking with my pharmacist about additional drug interactions and side effects regarding this medication.

I have been educated about the importance of reporting all side effects that I experience, including, but not limited to, which side effects to report immediately to a health care provider.

I agree to tell my provider about other medications I may be taking, including prescribed and over-the-counter medications; what food and drug allergies I have; and what medical conditions I have.

If I should become or am pregnant, or breast feeding, I will discuss this with the provider before taking any medication. If I become pregnant after starting the medication, I will notify the provider immediately.

Patient Name: _____

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if applicable) Date

_____ _____
Provider's Signature Date