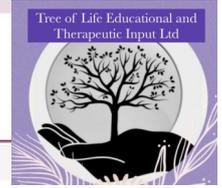


# MEDICATION CONSENT FORM



## PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH
ADDRESS	PHONE NUMBER
ALLERGIES	

## MEDICATION INFORMATION

NAME OF MEDICATION	DOSAGE	ROUTE	FREQUENCY
INDICATION			

## CONSENT

I, the undersigned, understand that the decision to use this medication is based on the professional judgment of the prescribing healthcare provider. I acknowledge that no guarantees or assurances have been made to me regarding the outcomes or effects of this medication.

I have been provided with information regarding the potential risks, benefits, and alternatives to this medication. I have had the opportunity to ask questions and have received satisfactory answers.

By signing this form, I hereby give my informed consent to receive the medication as prescribed above.

PATIENT SIGNATURE	DATE	
GUARDIAN/REPRESENTATIVE SIGNATURE <i>(If applicable)</i>	RELATIONSHIP TO PATIENT	DATE

## PRESCRIBER INFORMATION

PHYSICIAN/PRESCRIBER NAME	LICENSE NUMBER
PHYSICIAN/PRESCRIBER SIGNATURE	DATE

SAVE PRINT

PROVIDER NAME	CONTACT INFORMATION	Page 1 of 1
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