



Medication Informed Consent

Client: _____ DOB: ____/____/____

I acknowledge receiving an adequate explanation about medications, including:

- a. The advantage of taking the medication as prescribed to aid in recovery.
- b. The disadvantages and possible side effects associated with the medication.

Having received and understanding the educational information on the class of medication(s) that have been prescribed, I consent to the use of the medication. I understand that I may withdraw this consent at any time, but if not withdrawn, consent will remain in effect until the medication is discontinued by an authorized prescriber.

Medication	Date	Treatment Expectations
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

➤ _____ /____/____ _____ /____/____
 Parent/Guardian Signature Date Client Signature (If over 14 years) Date

_____ /____/____
 Witness Signature Date

➤ _____ /____/____ _____ /____/____
 Parent/Guardian Signature Date Client Signature (If over 14 years) Date

_____ /____/____
 Witness Signature Date

➤ _____ /____/____ _____ /____/____
 Parent/Guardian Signature Date Client Signature (If over 14 years) Date

_____ /____/____
 Witness Signature Date

➤ _____ /____/____ _____ /____/____
 Parent/Guardian Signature Date Client Signature (If over 14 years) Date

_____ /____/____
 Witness Signature Date

"REF" – Indicates client was given medication information but refused to sign – see medical record.