Patient Name: _____ DOB: _____

INFORMED CONSENT FOR MEDICATION

_____ M.D. has recommended that I take the medications listed below for the following condition(s) _____ _____.

The following have been explained to me or given to me in written form:

1. Benefits and risks of the medication(s).
2. Most common side effects of the medication(s).
3. Possible consequences if I do not take the medication(s) as prescribed.
4. Alternatives to this treatment and why the doctor is recommending treatment.

I understand that side effects may occur and that I should promptly notify the above named doctor of any expected changes in my clinical condition.
I also understand that I should notify the doctor of changes in my physical health, especially when pregnant or breast feeding. I understand that I need to notify the doctor if I am planning on becoming pregnant or if I become pregnant.

Medication(s) prescribed: _____
_____
_____

_____ _____
Patient/Parent/Legal Guardian Date

_____ _____
Witness Date