

Informed Consent for Medication

Name:

Name of Medication:

Dosage:

Reason for Medication:

Common Side Effects:

Benefits:

Medication Prescribed by:

I have been informed that the above medication has been prescribed for the purposes listed. I am aware of the side effects, and feel the benefits of the medication support its use. I hereby give my permission to (name of provider) to authorize administration of the prescribed medications.

This consent will expire one year from the date of consent. I understand I may withdraw my consent at any time by informing (name of provider). I understand if I fail to reply to give consent either verbally or written after three documented attempts my consent is implied and the medication will be given as prescribed.

Signature of Individual

Date

Signature of Parent/Guardian

Date

Documented Attempts - *example: USPS, phone, in person, through e-mail*

How was the attempt made?	Date of attempt	Initials