MEDICATION CONSENT FORM

Name:	DOB:	Date:

Dr. ________________ has educated me regarding medication that has been prescribed to (please check one of the following) ☐ me, ☐ my child regarding the benefits and possible side effects of this medication, possible drug, and/or food interactions that may occur while taking this medication, and the possible effects of this medication if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed.

I also provide consent to my prescriber to have access to my past prescription history.

____ _________________________________

(Signature of Patient / Parent / Guardian) (Date)

- It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor BEFORE taking any medication.
- It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report IMMEDIATELY to a health care provider.
- It is recommended that any provider prescribing medications to obtain a thorough patient history that should include (but may not be limited to):
    1. What medication including prescribed over-the-counter medications, the patient is or has been taking.
    2. What food or drug allergies the patient has
    3. What medical conditions the patient has.
- Patient (or guardian) has verbalized understanding of medication education.