CONVENTIONS PSYCHIATRY & COUNSELING
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MEDICATION CONSENT FORM

Patient: _____ Date: _____

Medication Prescribed/ Administered	Dosage	Frequency	Effects / Side Effects Explained	Method of Administration

I have been informed of prescribed medications, methods of administration, as well as the below noted information:

- The foreseeable risk of using prescribed medication
- The probable side effects, if any, and how they can be controlled
- Precautions regarding the use of other medications, alcohol/illicit drugs with these prescribed medications
- Proper storage of the medications
- The benefits expected from using these medications
- The available alternative, if any, and how they can be controlled
- The complications, if any, related to prolonged use of the medication
- How and why to take the medication
- Who to contact if I have any questions regarding the medications prescribed

I understand that my signature verifies that I am able to self-administer my medication.
(If client is minor, signature by parent or guardian verifies their understanding of the above and ability to assist in administration of medication)

Signatures:
Physician / Designated Staff: _____ Date: _____

Patient: _____ Guardian: _____

90 Day Review Signatures

DATE	PHYSICIAN/STAFF	PATIENT	GUARDIAN