MEDICATION CONSENT FORM

(For psychotropic medication)

UPDATE ANNUALLY OR AS CHANGES OCCUR

I, ______________________________, have been made aware of the possible side effects of the following psychotropic medications prescribed by my doctor.

Name of Medication(s): ____

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I give my informed consent to take these medications.

____ __________________

Individual Date

____ __________________

Legal Guardian Date

____ __________________

Witness Date