



TM

Medication Consent

Today's Date: _____

_____ is being prescribed _____
Name of Patient (Please Print) Name of Medication(s) (Please Print)

1. The benefits of this medication have been explained to me, as well as the risks and most common side effects associated with this medication. I am to report any side effects, concerns, or questions to Melmed Center.
2. I understand that there are both medical and non-medical alternatives to this treatment, including counseling, behavioral interventions and classroom and work accommodations
3. I will inform my/my child's healthcare provider about any other prescription or nonprescription medication taken and any illnesses or pregnancies occurring while on this medication. I will inform other specialists involved in my or my child's care (including pediatrician and obstetrician) of my decision to take this/these medication(s).
4. I understand that there are risks when taking medication while pregnant and lactating that can impact my health and the health of my baby.
5. I understand that this medication IS/IS NOT being used off-label (being used for reasons or for age group not specified in the medication label)
6. Rarely, medications can cause serious side-effects, such as blood sugar changes, blood pressure and/or pulse changes, blood disorders, liver damage, prolactin increase, tics, increase in suicidal behaviors, cardiac arrest, breast enlargement, hair loss, skin depigmentation and sudden death. This is not a complete list of side effects.
7. I will review effects and side effects with my/my child's pharmacist and read the accompanying medication package insert to learn of possible side effects.

I have reviewed the above information and have had the opportunity to ask questions. I understand and accept the responsibility of administering this medication and monitoring this for myself/my child while on the medication.

Signature of Patient or Representative

Relationship to Patient (Please Print)