Example Informed Consent for Medication Administration Services

Name of Medication

Patient Information

Name

First Name_____ Middle Initial_____Last Name_____

Date of Birth _____/_____ /_____

Sex/gender: ☐ Male ☐ Female

Address

Street _____

City _____State_____Zip _____

Home Phone _____

Work Phone_____Mobile Phone _____

Caregiver/Other Contact

Name_____

Home Phone Number_____

Work Phone Number _____

Mobile Phone Number _____

Relationship to Patient_____

Primary Care Provider

Name_____

Office Phone Number_____

Prescriber for Administered Medication

Name_____

Office Phone Number_____

Insurance Information

Plan Name_____

Policy/ID Number_____Group Number_____

Phone Number _____

By my signature below, I consent to the administration of the prescribed medication by a pharmacist or a supervised student pharmacist, where permitted by law, and to be contacted at the phone number provided above regarding this pharmacy service. I also release the pharmacy and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this medication. I understand that:

- I have voluntarily chosen to receive the medication.
- I am of legal age and authorized to execute this consent form.
- I will immediately alert the pharmacist and the prescribing physician of any medical conditions which may adversely affect my personal health or effectiveness of the medication.
- I have received education about potential side effects of the medication, when they may occur, and when and where I should seek treatment. I understand that if I experience any side effects, I am responsible for following up with my prescriber at my expense.
- I have had the opportunity to ask questions about the medication, and all my questions have been answered. I understand the benefits and risks of the medication.
- I understand that my receipt of this medication is subject to reporting, by my pharmacy or its business associate, to my primary care physician, the prescribing physician, and/or the manufacturer, if required, and I authorize these disclosures.
- I authorize the pharmacy to bill my insurance provider for services.
- I understand that a copy of my medical records will be stored in a confidential manner.

Patient

Print Name _____ Signature_____Date _____

(For Pharmacy Use Only)

Medication Name	Lot	Expiration Date	Manufacturer	Dose

Date of Administration	Time of Administration	Route of Administration	Site of Administration

Signature of Pharmacist _____

Date_____