

Medication Consent

I, _____, hereby authorize the staff of _____
(Resident's name) (Program name)

to safeguard my medications, supervise their administration and communicate with my physician regarding my medications. I understand that I may also be asked to leave my children's medications with the staff.

I understand that my medications will be kept in a locked cabinet.

I understand that I will not take any narcotic medication or benzodiazepines (exception: prescribed methadone). I will work with my physician and program staff in order to procure a non- narcotic prescription.

I agree to take my medication per my physician's orders. If I refuse to take my prescription medications, I understand that my residency at _____ may be re-
(Program name)
evaluated.

Resident Signature

Date

Staff Signature

Date

