INFORMED CONSENT FOR TAKE HOME INJECTION(S)
[name of medication and strength]

PATIENT INFORMATION

First Name: ________________________________ Last Name: ________________________________

MEDICATION ADMINISTERED

Week 1	Week 2	Week 3
Units: ________	Units: ________	Units: ________
Lot#: ________________	Lot#: ________________	Lot#: ________________
Exp: ___________	Exp: _________	Exp: __________

PRESCRIBER FOR ADMINISTERED MEDICATION
[Clinic Name]
[Doctor's Name license, expiration date and NPI#]
Office Phone Number:

By my signature below, I consent to the administration of the prescribed medication by a **[Clinic Name],** where permitted by law. I also release the pharmacy, **[Clinic Name]** 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 acknowledge I have requested **[Clinic Name]** to prepare and provide to take home medication.
- I understand dosing of medication. I am responsible for following up and discussing with prescribing physician/ **[Clinic Name]** regarding dosing and adverse side effects.
- I understand any medications ordered by me and administered are non-returnable in accordance with applicable laws.

I have read and understand the information provided by **[Clinic Name].**

Signature____

Print Name ____

Date _____________