Healing Hands Resource Center

Safe Place Clinics

Integrated Health Services

Name: **DOB:** **Insurance ID No:**

WRITTEN MEDICATION CONSENT

Patient Address____

I HEREBY GIVE MY CONSENT FOR:(Prescriber)_Dr. Yihoodah Green, ph: 773-467-6967, TO PRESCRIBE TO ME THE FOLLOWING PRESCRIBED/NON PRESCRIBED MEDICATIONS .

Medication Name	Dose	Targeted Symptoms	Possible Side Effects

EFFECITIVE UNTIL:_1 year after dated signature

Patient Signature: ________________________
(If over 12 yr old)
Printed Name: ________________________

Guardian Signature: ________________________
(If applicable)
Printed Name: ________________________

Date: ________________________