

**Clark Quality Care, LLC**  
**Psychotropic Medication Acknowledgment Form**

**Resident Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date:** \_\_\_\_\_

By signing this form, I acknowledge the following:

1. I have been informed that I am currently prescribed psychotropic medication(s).
2. I understand that these medications are used to support my mental and emotional well-being.
3. All medications are administered under the direction of a licensed medical provider.
4. If a medical provider determines that a change in medication is necessary while in care at Clark Quality Care, the change may be made based on clinical judgment and necessity.
5. A record of any changes will be maintained and available upon request.

**Resident Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*A copy of this form will be kept in the resident's file and available upon request.*