

# THE BARRACKS RECOVERY

## MEDICATION FORM

This form must be completed by any resident currently taking prescribed medication. All medications must be disclosed to ensure safety and compliance with The Barracks Recovery policies.

### RESIDENT INFORMATION

Full Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Medication Name	Dosage	Frequency	Reason/Condition

### ALLERGIES

List any known allergies (medication, food, or environmental)

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### MEDICATION MANAGEMENT AGREEMENT

By signing below, I understand and agree to the following:

1. I must take my medications exactly as prescribed.
2. I must store all medications safely as required by house policy.
3. I will not share, trade, or misuse any medication.
4. I will report any changes in medication to staff immediately.
5. Narcotic or controlled substances may require special approval or may not be permitted.
6. Failure to disclose medications may result in discharge from the program.

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

Printed Name: \_\_\_\_\_

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

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