

**Off-Site Custody of Medications**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that the following

*Person accompanying client*

medications are in my custody for \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Client’s Name*

Staff have instructed me regarding administration, times to be given, and the purpose for each medication. I acknowledge that I am responsible for correctly administering medications while the medication is in my custody.

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*Printed Name / Signature of Person Accepting Medications Date/Time*

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*Printed Name / Signature of Staff Transferring Medications to Person Accepting Medications Date/Time*

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*Printed Name / Signature of Staff Receiving Medications on Return Date/Time*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Printed Name / Signature of Person Returning Medications Date/Time*

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| --- | --- | --- | --- | --- |
| **Name of Drug and Dose** | **Administration Times** | **Purpose of Drug** | **Quantity Released** | **Quantity Returned** |
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Provider contact person: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #\_     \_\_\_\_\_\_\_

Primary physician: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #\_     \_\_\_\_\_\_\_