agency for persons with disabilities
State of Florida

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.

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

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

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

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

Name of Drug and Dose	Administration Times	Purpose of Drug	Quantity Released	Quantity Returned

Provider contact person: _____ Telephone #_____

Primary physician: _____ Telephone #_____