**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 #\_     \_\_\_\_\_\_\_