

Off Site Custody of Medications

Today's Date \_\_\_\_\_

I \_\_\_\_\_ (Name of Responsible Person) acknowledge that the following medications are in my custody for \_\_\_\_\_ (Name or Person Served). The Agency's staff have instructed me regarding administration times and purpose for each medication in my custody.

Rx #	Prescriber	Med Name	Dose of Med	Purpose for Med	# Released	# Returned
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Rx #	Prescriber	Med Name	Dose of Med	Purpose for Med	# Released	# Returned
16						
17						
18						
19						
20						

Signature of Responsible Person \_\_\_\_\_

Signature of Staff Releasing Meds \_\_\_\_\_

**UPON RETURN**

Signature/Credentials of Staff Receiving Meds/Completing Form

\_\_\_\_\_ Date \_\_\_\_\_

**COMMENTS/NOTES**

***All entries in this section must be dated and initialed by the MAS Nurse***

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