Over-the-Counter Medication Log Form

Name:	ID #:	Medication Allergies:
Medication:	Medication Strength:	Doctor:
Label Instructions:	Reason:	
Start Date:	Side Effects:	

Month		Year	

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Youth																															
Youth																															
Youth																															
Youth																															

Is above a new medication? Yes ☐ No ☐ If yes, education provided to youth on ________________ by ________________ Education to Guardian on ________________ by ________________

MM/DD/YYYY Staff Name MM/DD/YYYY Staff Name

Informed consent for new psychotropic medication granted by Guardian ________________ on ________________ by ________________

Guardian MM/DD/YYYY Staff Name

Names and Initials of Staff Completing Form				***Key**			
Name (Please type or print)	Initials	Name (Please type or print)	Initials	**MEDICATION:**			
				Not Given	**O**	Away from program	**A**
				Refused	**R**	Wrong time	**Time/initials**
				Given at school	**S**	As needed	**Time/initials**

* Use back of form to document medications not given, side effects, etc. Include date, time, explanation, and signature. **Notify supervisor of the incident.**

Reviewed by supervisor (signature): **Date:**