



### Medication Receipt Log

<b>Youth:</b>	<b>DOB:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Facility:</b>	<b>Date Received:</b>	<b>Time Received:</b>	

MEDICATION	STRENGTH	RX NUMBER	AMOUNT RECEIVED	DOSAGE FREQUENCY	CONTAINER TYPE B – Bottle U – Unit of Use O- Other
					<input type="checkbox"/> B <input type="checkbox"/> U <input type="checkbox"/> O
					<input type="checkbox"/> B <input type="checkbox"/> U <input type="checkbox"/> O
					<input type="checkbox"/> B <input type="checkbox"/> U <input type="checkbox"/> O
					<input type="checkbox"/> B <input type="checkbox"/> U <input type="checkbox"/> O
					<input type="checkbox"/> B <input type="checkbox"/> U <input type="checkbox"/> O
					<input type="checkbox"/> B <input type="checkbox"/> U <input type="checkbox"/> O

Yes    No  
 Rx verified with Physician Desk Reference (PDR)/Pharmacy or pill #, etc.?  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_

Yes    No  
 Facility physician gave verbal order to continue with Rx?  
 Date: \_\_\_\_\_ Time: \_\_\_\_\_

Health Care Staff Signature/Title: \_\_\_\_\_