MEDICATION RECEIPT, TRANSFER & DISPOSITION FORM

Please complete this form when a youth is discharged from a facility or transported to another facility. Medications must be in the original pharmacy container. The Youth's Name, Physician, Medication Name and Dosage must be legible on the label. There can be no changes written on the label. Any medication brought into the facility that is not in the original container cannot be accepted

Name of Youth

Youth's Name: ______________________ DJJID#: __________ DOB: ______ Allergies: ______________

Originating Facility

Facility/Program Name: ______________ Address, City, State: ______________________ Phone #: __________

Destination Facility

Facility/Program Name: ______________ Address, City, State: ______________________ Phone #: __________

Chain of Custody for Medication *(See Attached Transport Card)*

Date	Time	Staff Name/Title *(Printed)*	Signature

Medication Transfer Receipt

Name of Medication	Strength	Quantity	Prescribing Physician	Telephone #	Verified	Staff Initials
					☐Yes ☐ No	
					☐Yes ☐ No	
					☐Yes ☐ No	
					☐Yes ☐ No	
					☐Yes ☐ No	
					☐Yes ☐ No	
					☐Yes ☐ No	
					☐Yes ☐ No	

INTAKE MEDICATIONS RECEIPT: (COMPLETE THIS PORTION - Bringing medications from home)

Printed Name of Person Delivering Medications*:* ☐ DJJ Staff ☐ Parent/Guardian Releasing Medications ______________

Delivery Signature: ______________________ Facility/Parent Contact #: ______________

Printed Name/Title of Person Accepting Medication(s): ☐ DJJ Staff ☐ Parent/Guardian ☐ Youth, if 18, or ☐ DCF ______________

Signature of Person Receiving Medications: ______________________

Witness Printed Name/Signature: ______________________

FOR THE PURPOSE OF RELEASE: I understand that these medications are not in a child-proof, safety container, and I agree to accept these medications without a child-proof, safety container. I understand that if I do not agree to accept these medications without a child-proof, safety container, the DJJ representative is not authorized to provide me with any medications. In consideration of agreeing to accept these medications in a non-child-proof, non-safety container, I assume full and complete responsibility for the use and storage of medications from this date forward.

Pending Appointments: ______________________