Medication Transfer Form

Instructions:

1. Use this form when medication is sent with a child/youth.

2. Fill in the child's name, date of birth and the date the form is completed.

3. List the names of the medications and dosages being released, instructions on how and when they should be taken, the last time the medication was taken, the number of pills or number of bottles for liquids, or number of tubes for creams/ointments being sent and the number of refills left (enter a zero if none).

4. The care giver from the sending placement fills in the name and phone number of the family’s social service worker in case there are questions or discrepancies.

5. In the next box, the person releasing the medication signs and dates the form.

6. Then the transporting person (if applicable) signs and dates the form.

7. Finally the person receiving the medication signs and dates the form. The signatures mean the medication(s) and count(s) are correct.

8. The new caregiver should keep a copy of this form, a copy given to the family social service worker for the case file and the original kept in the Medical Passport.

9. Please print and sign legibly.

**Child/Youth’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_

 **Social Service Worker’s Name***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Phone*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

The following medication(s) are being transferred:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Prescribing Doctor’s Name | Doctor’sPhone Number | Medication, dosage and how to give the medication | Last Time Given | Number of pills/ bottles/tubes | Number of refills left |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

 By signing below you are agreeing that all medications and counts are accurate as listed above.

 Signature of Person releasing medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_

 Signature of Person transporting Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_

 Signature of Person receiving the medication(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_

**Note: Some medication may not be in "child proof' containers. Please keep all medications out of the reach of children**.

If there are questions or concerns related to this medication transfer, please contact your social service worker immediately.

File: Original in Medical Passport

 Copy with person releasing medication(s) and

 Copy with all signatures in Professional Section