



Medication Inventory Form

Youth: _____

Case #: _____

Unit: _____

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Is the medication approved by the parent, guardian, and/or case worker?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Has the medication been filled within the last 12 months? (Check 'discard after' date)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do all the pills in the bottle match?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Is the resident currently taking this medication (no missed doses for past 3 days)?

If 'No' to any of these questions, then hold the medication until clarification is received from the parent, guardian, or case worker.

If unable to contact the guardian then please complete the following:

I have made a diligent effort to contact the legal guardian to obtain consent for the administration of prescribed medications while the youth is in the facility. Despite these efforts, I was unable to obtain verbal or written consent from the guardian.

In the absence of guardian consent, and in coordination with the University of Utah College of Nursing on-call provider, the medications will be administered as prescribed by the youth's healthcare provider in order to safeguard the health and well-being of the youth while they are in our care.

Initials of JJYS Staff: _____ On-call Provider: _____ Date: _____

MEDICATION RECEIVED

*List the medication type (pill, capsule, tube, cream, ointment, and/or suppository) AND the amount received

Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	

X (parent/guardian) X

I give permission to administer this medication as prescribed. Signature of Staff Receiving Medication

MEDICATION RELEASED

*List the medication type (pill, capsule, tube, cream, ointment, or suppository) AND the amount released

Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	
Medication:		Type:		Amount:	

Medications RELEASED to (Print)

Relationship _____ Date _____

Signature of Person Medication Released to

Release Staff (Print/Sign)

MEDICATION DISPOSAL

Date:

Location of Medication disposal:

Signature of Staff Disposing of Medication:

Signature of Witness to Medication Disposal: