Medication Release Form

Resident's Name:_____ Date:_____

□ Leave of Absence	Dates/Times:_____	□ Move out	Date:_____

Name of person responsible for assisting/administering medications:_____

Medication	Strength	Directions	Quantity	Comments/Special Instructions

Family/Responsible Party Statement

Understand that these medications are not in childproof containers unless otherwise noted. I understand and accept responsibility of this medication regimen and have taken possession of these medications for the: □Leave of Absence □ Move Out

Signature of Family/Responsible Party:	Date:	AFH Signature:	Date:

Leave of Absence Return Information

Date/Time of Return:	Any unusual medications-related experience or discrepancies:
Explain:	

Completed forms are to be placed into individual patient charts.