ARIZONA'S CHILDREN ASSOCIATION

Transfer of Medication

Attachment 5

Date: _____ Time _____Child:
_____

Medication Name **Quantity** **RX#** **Doctor**

1._____

2._____

3._____

4._____

5._____

6._____

Prescriptions _____Yes _____ (#_____) _____ No
Special Instructions:
_____
_____

Sig. of person releasing medication: _____

Sig. of responsible party transporting medication: _____

AzCA Staff? Yes_____ No_____

Sig. of person accepting medication: _____

Sig. of person disposing of medication: _____

Note: An appointment will need to be scheduled, with your child's Psychiatrist for continued medication monitoring. This appointment should be made as soon as possible in order for your child to obtain his/her next prescription(s).

Approved by MRD 10-16-08
Reviewed by AB 6.2013

FC Approved 09/25/02