

# Washoe County Human Services Agency

## OTC (Over-The-Counter) Medication Administration Log

Month: \_\_\_\_\_  
Year: \_\_\_\_\_

Child: \_\_\_\_\_  
 Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Caseworker: \_\_\_\_\_  
 Careprovider: \_\_\_\_\_  
 Careprovider phone: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

By initialing each date/time of administration, you are verifying: 1. Written consent has been obtained from the parent/guardian to administer the medication. 2. I have administered the medication to the child myself and have witnessed him/her take it. 3. I will report all medication errors and/or adverse reactions by the child, to the guardian within 24 hours (verbally) and within 2 working days (in writing) and will be written into the notes section. 4. I understand the possible side effects and interactions of the medication (ask your pharmacist).

	Day of month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
<b>Medication:</b>	TIME																																				
Package and/or label instructions: administer _____ every ____ hrs as needed for _____	Initial																																				
	TIME																																				
Dr. override (explain below)? <input type="checkbox"/>	Initial																																				
	TIME																																				
Notes (concerns, errors, overrides, exceptions to instructions, dosing, etc.): _____	Initial																																				
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