

MEDICATION RELEASE

Date: _____

I, _____, have received the
(Printed name of Careloft representative)

medications listed below from a responsible person(s). I understand that these medications are to be administered to

(Name of person to whom the medications are to be administered)

I have been provided instructions regarding the physician's orders. Careloft accepts responsibility for the administration of the following medications:

Medication / Purpose _____

Quantity _____

Times Administered _____

Medication / Purpose _____

Quantity _____

Times Administered _____

Medication / Purpose _____

Quantity _____

Times Administered _____

Medication will be taken at Careloft

No medication will be taken at Careloft

Signature of Responsible Person

Date