Washoe County Human Services Agency
OTC (Over-The-Counter) Medication Administration Log

Month: __________
Year: __________

Child: ______________________________
Age: __________ DOB: _______________
Caseworker: _________________________
Careprovider: ________________________
Careprovider phone: _________________

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
Medication:	TIME																															
Package and/or label instructions: administer _______________ every ____ hrs as needed for _______________________________ .	Initial																															
	TIME																															
	Initial																															
Dr. override (explain below)? ☐	TIME																															
Notes (concerns, errors. overrides, exceptions to instructions, dosing, etc.): _____________________	Initial																															
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HSACS 597 ***PLEASE NOTE: no child in the custody of Washoe County may be administered an ingested OTC medication without being consented to (using HSACS 598) and logged.***