Cabarrus County Client Shelter Cold Storage Medication Log

Incident Name: _____ Shelter Name/Location: _____

Client Name: _____ DOB: _____

Best Contact Phone Number: _____

Notes: _____

Medication Name		Dosage	Frequency	Exp. Date	Packaging
1.					
2.					
3.					
4.					

MEDICATION INTAKE			
Medication received by:		Date:	Time:
Refrigeration temperature at time of receipt:			
Client signature:			

MEDICATION RETURN / DISPOSAL			
Medication (check one): ❑ Returned to client ❑ Disposed			
Staff signature:		Date:	Time:
Client signature (if returned):			