

# CABARRUS COUNTY SHELTER OTC MEDICATION LOG

Incident Name: \_\_\_\_\_ Shelter Name / Location: \_\_\_\_\_

Date	Time	Client Name (please print)	DOB (please print)	OTC Medication Name	Lot #	Exp. Date	Amount self- administered by client	Signature of client or parent / guardian if client is less than 18 years old	Shelter staff initials