



• **Red Mountain Family Services, Inc.** ♦ PO Box 67197 ♦
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Over-the-Counter Medication Log

Name: _____ Month/Year _____

Allergies: _____

Date	TFP Initials	Name of Medication Given	Reason Medication was Given

TFC Parent Signature: _____ TFP Initials: _____

TFC Parent Signature: _____ TFP Initials: _____

Respite Parent Signature: _____ TFP Initials: _____

TC Initials and Date: _____

Please list OTC products taken daily on the back of this form, ex: multivitamins, MiraLax, iron supplements, allergy medication etc.

List all Over-the-Counter products administer daily to placement for example multivitamins, MiraLax, iron supplements, allergy medication etc. Please list time of day given (AM only, AM and PM, PM only) and dosage.

Also please make note of any dosage changes, start and stop dates (if not given the entire month), or any other pertinent information.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Please note: This log is due to the treatment coordinator, same as the MAR form, at the end of every month.