Photo Area

Medication Distribution Log (MDL)

Facility Name	
Common Side Effects/Precautions:	
Allergies:	

Codes:

AB	Absconsion
R	Refusal
TR	Temporary Release
SE	Side Effects
Ø	No side effect
O	Not Distributed

Example:

SI/YI	Staff Initials/Youth Initials
SI/SI	Staff Initials/Staff Initials

Medication: ____________________ **Strength:** ______ **Reason for med:**_______________		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
Method of Directions: (Insert#________) QTY/AM □ Oral □ Tab □ Cap □ ml/cc □ Topical □ Injectible □ Inhalant □ Ear drops □ Eye (Insert#_______) times Daily	Time:																															
	Remaining Count:																															
2nd or mid day daily dose (Insert#_____)QTY:Noon □ Oral □ Tab □ Cap □ ml/cc □ Topical □ Injectible □ Inhalant □ Ear drops □ Eye	Time:																															
	Remaining Count:																															
3rd or PM Daily dose: (Insert#________)QTY/PM □ Oral □ Tab □ Cap □ ml/cc □ Topical □ Injectible □ Inhalant □ Ear drops □ Eye	Time:																															
	Remaining Count:																															
4th or bedtime Daily dose: (Insert#________)QTY/HS □ Oral □ Tab □ Cap □ ml/cc □ Topical □ Injectible □ Inhalant □ Ear drops □ Eye	Time:																															
	Remaining Count:																															
Side Effects Monitoring																																
Controlled Shift Inventory (use whole section for controlled inventory)	Time:																															
	Shift 1 Inventory:																															
	Staff Initials																															
	Time:																															
	Shift 2 Inventory:																															
	Staff Initials																															
Date Received: ___________ Time Received: ___________ Amount Received: _________ Received From: __________	Time:																															
	Shift 3 Inventory:																															
Non controlled Weekly Inventory (just use gray areas for non controlled inventory)	Staff Initials																															

Youth Name:	**Date of Birth:**		**Month/Year:**	
Client ID:	**Physician:**		**Pharmacy:**	
	Phone#		**Phone#**	

Youth Signature and Initials____

Contact and Codes
MDR page 2

Youth Name ______________________ Youth ID # ___________________________ DOB ____________

Allergies

DATE	TIME GIVEN	CODE	REASON	CONTACT	PHONE	SIGNATURE/TITLE

This area to be used for signatures required on front of MDL when medications are provided to youth

Initials	SIGNATURE	PRINT NAME	Initials	SIGNATURE	PRINT NAME

WEEKLY MDL REVIEW

DATE	SIGNATURE	PRINT NAME	TITLE