



**ALASKA CHILDREN'S SERVICES  
FAMILY TREATMENT HOMES  
TREATMENT PASS MEDICATION**

Start Date/Time: \_\_\_\_\_

End Date/Time: \_\_\_\_\_

**PLEASE USE THE FOLLOWING INSTRUCTIONS TO GIVE YOUR CHILD HIS/HER MEDICATIONS**

| Name of medication: | Dosage | # of tabs to be given: | Time med is due: | # Out | # In |
|---------------------|--------|------------------------|------------------|-------|------|
| 1.                  |        |                        |                  |       |      |
| 2.                  |        |                        |                  |       |      |
| 3.                  |        |                        |                  |       |      |
| 4.                  |        |                        |                  |       |      |
| 5.                  |        |                        |                  |       |      |
| 6.                  |        |                        |                  |       |      |

- Call \_\_\_\_\_ if you have any questions or problems with the above medications.
- Call the ACS on call at \_\_\_\_\_ if your child complains of any of the following problems: Nausea, vomiting, diarrhea, new onset of dizziness, jerking movements/twitching/shaking, or a rash. We may need to call an emergency room for medical advice.
- Call the ACS staff (at the above number) if any of the above medications were given more than an hour from the time listed above.
- Your child is on an antibiotic for \_\_\_\_\_. Do not stop giving this antibiotic even if the original symptoms have cleared.

Were all the meds given on treatment pass?     YES     NO

If NO, explain: \_\_\_\_\_

Your signature represents your agreement to accept the responsibility for the safekeeping and the return of any unused medication(s) belonging to the student as listed above.

*I relieve the ACS Treatment Parent, ACS staff, prescribing Physician, and the dispensing pharmacy from any liability that might arise from any misuse or overdose accruing to the acceptance of this medication, and I release the dispensing pharmacy from any liability that might arise, if the medications are not dispensed in childproof containers. I realize that I am responsible for any medication that is lost or misused.*

\_\_\_\_\_  
*Signature of parent/guardian/supervising adult*

\_\_\_\_\_  
*Date & Time*

\_\_\_\_\_  
*Signature of ACS Treatment Parent releasing meds*

\_\_\_\_\_  
*Date & Time*

\_\_\_\_\_  
*Signature of ACS Treatment Parent upon return*

\_\_\_\_\_  
*Date & Time*

| Student Name | Student # | DOB |
|--------------|-----------|-----|
|              |           |     |