Medication Log

Name: ____________________ Date of birth: ________ Gender: _____ Allergies:_________ Month/Year:_________

Prescription medication- The administrator initials the box and records the time (indicating am or pm) under the appropriate day of the month for each dose given that day. If a dosage is changed by a child's physician, missed, refused, or given by an administrator that is not the foster parents or a substitute caregiver listed on the Licensed and Approved Family Foster Home Survey Instrument please mark the log appropriately.

Administered	Staff & Client Initial and time
Missed	M
Refused	R
Changed	C
Other caregiver	O

Medication Name:			**Dosage/Time(s):**		**# of pills given:**		**Route Given:**			**Purpose: Side Effects**			**Start Count:**		**Time:**
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	

Medication Name:			**Dosage/Time(s):**		**# of pills given:**		**Route Given:**			**Purpose: Side Effects**			**Start Count:**		**Time:**
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
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Over the Counter or other PRN Medications:

Date:	Time:	Dosage:	Route Given:	Purpose:	Signature:

Changes in behavior or adverse reactions:

Date:	Time:	Medication:	Dosage:	Route given:	Purpose:	Comments:

Missed medication, changed by physician or administered away from the home:

Date:	Time:	Medication:	Comments:	Signature:

Each administrator must sign and initial:

Signature of Administrators:	Initials:	Signature of Administrators:	Initials: