Medication Log

Client Name: &cltfst& &cltlst&

Client Case: &cltcas&

Medication Name: ________________________ Prescribing Physician/Phone #: ____________________
Pharmacy: _______________________ Prescription #: ________ Date Filled: __________
Refills ________ Yes _________ No Date of Refill: _______________ Amount: _____________

INSTRUCTIONS:
Dosage: ____________ Time to be given: ___________ Method of Administration: _________________
Person Admin. Medication: (Must be the Teaching parent, respite provider or school nurse) _______________________

Initial Count: ______________ **Month / Year:** ______________

DAILY ADMINISTRATION RECORD

Date	Time	Dosage Given	Initials	Count after Admin	Time	Dosage Given	Initials	Count after Admin	Time	Dosage Given	Initials	Count after Admin.
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Signatures	
Foster Parent Signature	**Date**