CHILD'S NAME: ____________________________ Foster Home: ________________________________ Month/Year: ____________________

Complete Name of Medication: ______________________________ Prescribed Dosage: ____

Prescription Refill Date: ______________________ Name of Doctor Prescribing Medication: ____

Please initial the box each time you give the medication!!! EXACT times must be noted!*

Date	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
Time (AM)																															
Initial																															
Time Noon																															
Initial																															
Time (PM)																															
Initial																															
Time (Bed)																															
Initial																															

Required Provider Signature: ____
Team Coordinator Signature Acknowledging receipt of form and accurate completion:____
Date form is placed into the child's file: _____________________

***Please observe child while taking medication. Continue to observe child for a short time after dispensing medication. If you believe child is trying to avoid swallowing his/her medication, please report this immediately to your team coordinator.**