Families First OF FLORIDA

Please submit the completed form to our office by the 5th of each month.

Medication Administration Log

Child's Name:		***Program:***		***Foster Parent(s):***	

Medication & Prescribing Physician	***Dosage***	***Reason for Medication***	***Frequency & Time of Day***	***MONTH OF ____________, YEAR OF ____________***																														
				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
			1)																															
			2)																															
			3)																															
			4)																															
			1)																															
			2)																															
			3)																															
			4)																															
			1)																															
			2)																															
			3)																															
			4)																															
			1)																															
			2)																															
			3)																															
			4)																															
			1)																															
			2)																															
			3)																															
			4)																															
			1)																															
			2)																															
			3)																															
			4)																															

My signature indicates that I have, **on a daily basis**, administered the prescribed dosage as evidenced by my initials on the medication log.

Medication Allergies

1)
2)
3)
4)
5)

______________________ Foster Parent Signature ______________ Date

______________________ Foster Parent Signature ______________ Date

______________________ Respite Provider Signature, if applicable ______________ Date

______________________ Staff Signature ______________ Date

M - Missed
R - Runaway
C - Crisis
D - Detention
S - School

F:\\2004-2006Forms\Clinical\Medication Log.xls

Updated 11/10