Immediately report medication error	
S-school	R- Refused Meds
D- Discontinued	O- Out of Med
A-Away from home	DN- Did not give med

Medication Log

Client Name:	Month/Year:	Page _____ of _____

Medication:	Dosage/Strength:	Instructions for Use:
Reason:	Prescribing Doctor:	

	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																															
Init.																															
Time																															
Init.																															
Time																															
Init.																															

Common Side Effects:	Side Effects Experienced This Month:

Medication:	Dosage/Strength:	Instructions for Use:
Reason:	Prescribing Doctor:	

	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																															
Init.																															
Time																															
Init.																															
Time																															
Init.																															

Common Side Effects:	Side Effects Experienced This Month:

Initial	Signature of caregiver administering medications this month	All medications, including over-the-counter meds, are stored in locked container Foster Parent's Signature: _____
		All Psychotropic medications are stored under double lock. Foster Parent's Signature_____
		Report All adverse reactions/side effects or medication errors to the child's doctor and your Case Manager. If after hours, contact the on-call worker at 832-510-0032