DHS
Oregon Department of Human Services

Foster Home
Individual Child Medication Log

Worker Name: _____ Case Number: _____

Name of Child: _____ Log Start Date: _____ End Date: _____

Name and initials of person dispensing medication: (please print): _____ Signature: _____

Instructions:

1) Write the name of the prescription medications, the dosage to be taken, and the amount of the dosage to be taken.
2) In the "Hour" column, indicate the time of day that the medication is to be taken; include AM or PM. Use one line for each time.
3) The person giving the medication will write their initials beneath the day of the month and across from the time of day that the medication was given. If a medication is skipped or missed, print and circle your initials in the box (date and time) when the dose was missed.

See examples on reverse side for specific instructions on how to complete the form. When this form is completed, return it to the caseworker and begin a new one.

Name of Medication Dosage Amount	DAY OF THE MONTH																															
	HOUR	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

THIS FORM IS AVAILABLE IN ALTERNATE FORMAT UPON REQUEST

Policy Ref: I-E.3.3.1
Yellow: Foster Parent
File: Client Case File - Medical Section

CF 1083 (7/05)

Instructions: How to complete the CF 1083, “Individual Child Medication Log."

- Complete one form for each child in care. More than one medication may be documented on each form.
- When the month has been completed, send the completed form to the child's caseworker and begin a new form. Make a copy for your records if you wish.
- Write the name of the medication, the dosage to be taken, and the amount of the dosage to be taken in the first column.
- In the “Hour” column, indicate the time of day that the medication is to be taken; include AM or PM. Use one line for each time of day that medication is prescribed.
- The person giving the medication will write their initials beneath the day of the month and across from the time of day that the medication was given. If medication is missed or skipped, please note on the form.

Name of Medication Dosage Amount	DAY OF THE MONTH																															
	HOUR	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
EXAMPLE ONLY EXAMPLE ONLY																																
Ritalin 10 mg.	7 AM	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St
	12 PM	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St
	4 PM	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St
Clonidine 0.1 mg	7 PM	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St	St
Amoxicillin 500 mg 3 X daily	7 AM													St	St	St	St	St	St	St	St	St	St									
	2 PM													St	St	St	St	St	St	St	St	St	St									
	9 PM													St	St	St	St	St	St	St	St	St	St									