

Month: _____ Year: _____

Youth's Name:	DOB:	Program:	Known Allergies
Medication:	Date of Order:	Frequency:	1
Dose:	Duration:	# Pills beginning:	2
Route:	Prescribed by:		3

	7am Dose ____ (#Pills ____)					12n Dose ____ (#Pills ____)					4pm Dose ____ (#Pills ____)					8pm Dose ____ (#Pills ____)					
	S1	S2	Y	BT	ET	S1	S2	Y	BT	ET	S1	S2	Y	BT	ET	S1	S2	Y	BT	ET	
1																					Additional Medication Added
2																					# Pills added: _____
3																					Date added: / /
4																					
5																					Dosage Change
6																					To: _____ From: _____
7																					Date changed: / /
8																					Youth Name
9																					Initials
10																					
11																					Staff/Foster Parent Name
12																					Initials
13																					
14																					
15																					
16																					
17																					
18																					
19																					
20																					
21																					
22																					
23																					Codes
24																					S1/S2 = staff initials
25																					Y = youth initials
26																					T = titration (B=beginning; E=End)
27																					E = error (must submit SIR)
28																					R = refused medication (refusal form)
29																					AWL = AWOL missed dose
30																					H = home pass/visit
31																					S = school
																					A = absent

COMMENTS:	Pills Destroyed		Reviewed by	
	# Pills:	Date: / /	Supervisor or CFS:	Date: / /
	# Pills:	Date: / /	Director:	Date: / /
	# Pills:	Date: / /	:	Date: / /
	# Pills:	Date: / /	:	Date: / /

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	# Pills:	Date: / /	:	Date: / /
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	# Pills:	Date: / /	Director:	Date: / /
	# Pills:	Date: / /	:	Date: / /
	# Pills:	Date: / /	:	Date: / /

OTC

MEDICATION ADMINISTRATION REPORT

OTC

Month:	Year:
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Youth's Name:

DOB:

Program:

Known Allergies	
1	
2	
3	

1	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

6	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

Youth Name	Initials

2	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

7	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

Staff/Foster Parent Name	Initials

3	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

8	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

4	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

9	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

Reviewed By

Title: Supv or CFS (circle)

Signature:

Date:

Title: Director

5	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

10	Date:	Time:	am/pm
	Medication:	Dose:	
	Reason:		
	S1: _____	S2: _____	Y: _____

Signature:

Date:

Title:

Signature:

Date:

Title:

Signature:

Date:

Comments:

