G.A. FAMILY SERVICES
FOSTER CARE

Health Care & Medication Log

Client Name: ____ D.O.B. __________________

Foster Parent name and Initials: ________________________________ Foster Parent Name and Initials: ______________________________

Month: __________________ Year: _____________ ☐ No medications administered this month. See back of form for Health care Record

Medication #1 ______________________________ Date Medication Ordered __________________ Reason ______________________________
Prescribing Physician ____________________________ Psychotropic Medication _______ Prescription Medication _______ OTC Medication _______

(Initial after each dose)

Time	Dose	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

Side Effects Noted for Medication #1 (Include Dates) ____

Medication #2 ______________________________ Date Medication Ordered __________________ Reason ______________________________
Prescribing Physician ____________________________ Psychotropic Medication _______ Prescription Medication _______ OTC Medication _______

(Initial after each dose)

Time	Dose	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

Side Effects Noted for Medication #2 (Include Dates) ____

Medication #3 ______________________________ Date Medication Ordered __________________ Reason ______________________________
Prescribing Physician ____________________________ Psychotropic Medication _______ Prescription Medication _______ OTC Medication _______

(Initial after each dose)

Time	Dose	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

Side Effects Noted for Medication #3 (Include Dates) ____

Medication #4 ___________________________________ Date Medication Ordered ____________________ Reason __________________________________
Prescribing Physician _________________________________ Psychotropic Medication ________ Prescription Medication ________ OTC Medication ________

(Initial after each dose)

Time	Dose	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

Side Effects Noted for Medication #4 (Include Dates) ____

Medication #5 ___________________________________ Date Medication Ordered ____________________ Reason __________________________________
Prescribing Physician _________________________________ Psychotropic Medication ________ Prescription Medication ________ OTC Medication ________

(Initial after each dose)

Time	Dose	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

Side Effects Noted for Medication #5 (Include Dates) ____

Health Care Record:

Document any illnesses, injuries, appointments or first aid administered

Date	**Incident**

____ _________________________
Foster Parent Date