SARNIA-LAMBTON CHILDREN'S AID SOCIETY

PRESCRIPTION ADMINISTRATION FORM

FOSTER CHILD: ______________________________ FOSTER HOME: __________________________________

DATE: ____

DATE/ TIME	NAME OF DRUG/ DOSAGE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	INITIAL
Observed changes in weight, behaviour, emotions, and physical state									

- Please identify each medication administered, and Foster Parent initial that the medication was taken.
- If child/youth refuse to take their prescribed medication, they are to initial that they are refusing.
- This form can also be used to record over-the-counter medication administered.