CFS 534
8/2002

State of Illinois
Department of Children and Family Services

MEDICATION ADMINISTRATION LOG

For the Month of: ____________________ **Year:** __________ **Child's Name:** ______________________________ **Child's Date of Birth:** ______________

Physician ordering medication: ______________________________ **Name of Medication:** ______________________________

Expiration Date: ______________________________ **Dose:** ____________________ **# of Times Given per/day** ____________________

Time Medication was given during the day	DAYS WITHIN THE MONTH																														
	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

Physician ordering medication: ______________________________ **Name of Medication:** ______________________________

Expiration Date: ______________________________ **Dose:** ____________________ **# of Times Given per/day** ____________________

Time Medication was given during the day	DAYS WITHIN THE MONTH																														
	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

______________________________ __________
Signature of person administering medication Initials

______________________________ __________
Signature of person administering medication Initials

______________________________ __________
Signature of person administering medication Initials

______________________________ __________
Signature of person administering medication Initials

INSTRUCTIONS

Foster parents who are caring for a child for whom the Department is responsible are required by Rule 402 to keep a log of all medications that are given to the child. Psychotropic medications as well as prescription and non-prescription medications for medical conditions should be included on this form. The foster parent is expected to complete this log on a daily basis and submit a copy of it to their caseworker once a month.

1. Each medication the child is given should be displayed on a separate chart. This is to include all over-the-counter medications such as aspirin, anti-nausea or anti-diarrhea medications.
2. The person administering the medication must initial in the appropriate box **each** time that any medication is given to the child.
3. If a dosage is missed, leave the box on the chart blank and complete the information requested below.
4. If a medication is started or finished during the month, draw a line through the days before and/or after.
5. The person(s) administering the medication is to sign and initial the form.
6. List dates of all appointments for medication, including unscheduled and cancelled visits, below.

MISSED DOSAGES (Give date, name of medication and reason)

__________ DATE   ____________________ NAME OF MEDICATION AND REASON   __________ DATE   ____________________ NAME OF MEDICATION AND REASON

__________ DATE   ____________________ NAME OF MEDICATION AND REASON   __________ DATE   ____________________ NAME OF MEDICATION AND REASON

APPOINTMENTS (Indicate if any were unscheduled or cancelled):

__________ Date ☐ Unscheduled ☐ Cancelled   __________ Date ☐ Unscheduled ☐ Cancelled

__________ Date ☐ Unscheduled ☐ Cancelled   __________ Date ☐ Unscheduled ☐ Cancelled