NATIONAL YAP
YOUTH ADVOCATE PROGRAM

Medication Log

Month: _____ Year: _____ Foster Home: _____

Youth Name: _____ Foster Home Address: _____

Medication/Treatment	Hours	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	Indicate side effects for each medication
																																	Dr:
																																	Dr:
																																	Dr:
																																	Dr:

Date	Shift	Initials	Full Signature	Date	Shift	Initials	Full Signature

1. Please initial in the appropriate box when medications are given. (Complete initial, signature line below.)
2. Put code in box on times where dose has not been give, noting why.
3. Put d/c in box if medication has been discontinued [X] and then line out all boxes following d/c for the month.
4. If new medication X all boxez prior to start date.
5. If any medication changes through the month please add medication changes on to log on the back of this form.

M - Missed RF - Refused W - AWOL
L - Leave / Visitaiton
SC - Given at school

YOUTH NAME: _____

DATE CHANGE BEGINS	NEW	DC	DOSAGE CHANGE	MEDICATION Include Dosage	PRESCRIBED BY:

Physician Name: _____ Phone Number: _____

Physician Name: _____ Phone Number: _____

Physician Name: _____ Phone Number: _____

Code:
D/C - discontinued
dosage chg. - dosage change