

Name: **Elsa Doe**

Month/Year: **April 2018**

Known Allergies/Sensitivities:

Penicillin

**Christian Heritage
Medication Log**

Turn in by the 10th of each Month

Example

START DATE: 4-10-18	HOUR GIVEN	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		
MEDICATION NAME/STRENGTH: Vyvanse 20 mg	8a	MRP		R			A																											
<input type="checkbox"/> OTC <input type="checkbox"/> PRN Rx#: 123456	3p	MRP																																
DOSE: 1 tablet ROUTE: By mouth	8p																																	
REASON: ADHD																																		
START DATE: _____																																		
MEDICATION NAME/STRENGTH:																																		
<input type="checkbox"/> OTC <input type="checkbox"/> PRN Rx#: _____																																		
DOSE: _____ ROUTE: _____																																		
DOCTOR: _____																																		
REASON: _____																																		

Name & Initials of Persons Completing Form

Name (Please type or print)	Initials
Mary Poppins	MP



CH FCS Signature/Date

Key

Medication:		Respite/Away/A	
Missed	M	Wrong Time	Time/Initials
Refused	R	As Needed	Time/Initials
Given at School	S		

Notes/Documentation:

4/13 Youth Refused medication: Contacted Caitlin
4/16 Youth on respite

11/11/16