

PRN PSYCHOTROPIC MEDICATION LOG

Name		Month	Year
Sex	DOB	DOA	
Allergies			
Physician Name		Phone Number	

Medication Name / Generic Name	Reason for Administration of Medication
Orders (Dosage information)	

Administered By (Initials of FP/Caregivers)	date	time	am/ pm	Medication	Dosage given	Reason, including specific symptoms, condition, and/or injuries

PRINTED NAME

SIGNATURE

INITIALS

PRINTED NAME

SIGNATURE

INITIALS

PRINTED NAME

SIGNATURE

INITIALS

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Administered By (Initials of FP/Caregivers)	date	time	am/ pm	Medication	Dosage given	Reason, including specific symptoms, condition, and/or injuries

FOSTER PARENTS/BCFS STAFF:** Please complete the following section. ***It cannot be left blank.
 Briefly note any positive and/or negative changes in child's behavior in response to this medication. If child
 Is maintaining or there are no noticeable changes, please indicate that with an appropriate statement below.

During this month, I have noted the following changes in child's behavior in response to this medication:

PRINTED NAME

SIGNATURE

INITIALS

PRINTED NAME

SIGNATURE

INITIALS