Athens County Children Services

Prescription Medication Log

Child Name: _____   Child's DOB: _____   Foster Home: _____   Month: _____

Please initial each time medication is given and note time   *Logs will be reviewed monthly by the assigned caseworker and placement caseworker.*

Medication	Time	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
Name of Medication:																																	
Dosage:																																	
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Please note any side effects or observations and report any adverse side effects to child's caseworker and prescribing physician within 24 hours