Uniting Hope4 Children
Placing Children & Supporting Families

MEDICATION LOG

1949 Hwy 81
Loganville, GA 30052
678-585-4686

Name of Child______________________ Month __________

Must be turned in monthly and signed by foster parent even if no medication is given.

DATE	MEDICATION	ADMINISTERED BY	TIME	DOSAGE	USAGE FREQUENCY	ACCEPTED/REFUSED MEDICATION

Foster Parent(s) Signature: ____

Case Manager Name: ______________________________ **Phone Number:** _____________________

Physician Name: __________________________________ **Phone Number:** _____________________