Uniting Hope4 Children
Placing Children & Supporting Families

MEDICATION LOG

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

Name of Child_____________________________ **Month/Year** __________________

Must be turned in monthly and signed by foster parent even if no medication is given.
If medication is given, it must be recorded at time of administration.

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

Foster Parent(s) Signature: ____

Case Manager Name: ___________________________ **Phone Number:** ___________________

Physician Name: _______________________________ **Phone Number:** ___________________