|  |  |  |
| --- | --- | --- |
| Logo  Description automatically generated | **FOSTER CARE****INDIVIDUAL YOUTH MEDICATION LOG** | State of OregonOREGON YOUTH AUTHORITY |
| Youth Name: |  | JJIS #: |       | Log Start Date: |  | Log End Date: |  |
| Foster Care Certifier Name: |       | Parole/Probation Officer Name: |       |
| Name & initials of person dispensing medication (please print): |       | Signature: **X** |  |

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| --- | --- | --- | --- | --- | --- |
| **Name of Medication** |       | **Dosage & Frequency** |       | **Prescribing Physician** |       |
| **Purpose** |       |
| **TIME OF DAY** | **DAY OF MONTH** |
| **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** |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Comments** |       |

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| --- | --- | --- | --- | --- | --- |
| **Name of Medication** |       | **Dosage & Frequency** |       | **Prescribing Physician** |       |
| **Purpose** |       |
| **TIME OF DAY** | **DAY OF MONTH** |
| **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** |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Comments** |       |

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| --- | --- | --- | --- | --- | --- |
| **Name of Medication** |       | **Dosage & Frequency** |       | **Prescribing Physician** |       |
| **Purpose** |       |
| **TIME OF DAY** | **DAY OF MONTH** |
| **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** |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
|      [ ]  AM [ ]  PM |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Comments** |       |

**Instructions for completing YA 3105, Individual Youth Medication Log**

Complete one form for each youth in care; more than one medication may be documented on each form.

1. Enter the name of the medication, dosage and the frequency to be taken, and prescribing physician in the 1st row.
2. Indicate the purpose of the medication in the 2nd row. This information should be obtained from the prescribing physician.
3. In the ‘Hour’ column, indicate the time of day that the medication is to be taken, include AM or PM; use one line for each time of day that medication is prescribed.
4. The person giving the medication enters their initials under the day of the month and time of day the medication was given. If medication is not given, use the key below\* to designate the reason and provide a note explaining reason.
5. Note on the chart when a medication has been discontinued.
6. At the end of the month, sign the completed form and send to the Foster Care Certifier, retain a copy for your records, and begin a new form for the following month.

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| --- | --- | --- | --- | --- | --- |
| **Name of Medication** | **Prednisone** | **Dosage & Frequency** | **5 mg/****2x daily for 14 days** | **Prescribing Physician** | **Dr. David Bell** |
| **Purpose** | **Reduce inflammation in joints** |
| **TIME OF DAY** | **DAY OF MONTH** |
| **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** |
| **7:00****[x]  AM [ ]  PM** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **6:00****[ ]  AM [x]  PM** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST** | **ST**SAMPLE | **ST** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **[ ]  AM [ ]  PM** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Comments** | **Note that medication was discontinued after the 14th as prescribed by the physician** |

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| --- | --- | --- | --- | --- | --- |
| **Name of Medication** | **Metadate** | **Dosage & Frequency** | **30 mg/****1x daily** | **Prescribing Physician** | **Dr. Sheila Davis** |
| **Purpose** | **ADHD** |
| **TIME OF DAY** | **DAY OF MONTH** |
| **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** |
| **7:00****[x]  AM [ ]  PM** |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ***ST*** | ***ST*** | **U** | ***ST*** | ***ST*** | ***ST*** | ***ST*** | ***ST*** | ***ST*** | ***ST*** | ***ST*** | ***ST*** | ***ST*** | **M** | ***ST*** | ***ST*** |  |
| **[ ]  AM [ ]  PM** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **[ ]  AM [ ]  PM** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Comments** | **17th – Give reason for unavailable medication; 28th – Give reason youth missed dosage.** |

**\*Medication Administration Key**

M = Missed R = Refused by youth U = Unavailable O = Other