Pathways Family Services Multiple Medication Sheet

Child/Youth Name: ______________________________ Month/Year: ____________________

Please document name of medication and the time of administration. Caregivers are required to document all medications taken by a child/youth. This includes such over the counter medications as pain killers and cough medicine. Enter the time, date & type of medication taken below and initial. If the child administers their own medication (with Case Worker's approval), the child needs to initial.

TYPE OF MEDICATION: **DOCTOR'S NAME:**

Dosage	Times	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

TYPE OF MEDICATION: **DOCTOR'S NAME:**

Dosage	Times	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

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Foster Home: ______________________________ **Signature:** ______________________________