

Child: _____ Foster Parent: _____ Initials: _____

DOB: _____ Foster Parent: _____ Initials: _____

Medication:	
Physician:	Ph:
Directions:	
Uses:	
Common Side Effects:	
Description:	Markings:



Codes for Documenting: Initials = medication given, Circled Initials* = Missed dose, R* = Refused (*turn in an incident report)

CVS Store # _____ Address: _____ Ph: _____

Rx #: _____ Month: _____

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

Please complete this for and turn it in monthly with your Monthly Documentation of Treatment.

Track administration of new medications on this sheet until your personalized Medication Administration Record arrives.

If you don't receive your sheet in 7 days, please contact the CVS/pharmacy Outreach Program

(216) 382-4782

Staff available M-F 8:00AM-12:00AM, Sa-Su 10:00AM-6:00PM