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| **MONTH:**  **YEAR:** | **MEDICATION ADMINISTRATION LOG** | | | | | | | | |
| **CHILD’S NAME** |  | | | | **FOSTER PARENT:** | | | | |
| ALLERGIES |  | | | | | | | | |
| **DOCTOR NAME** |  | | | | | **CASEWORKER:** | | | |
| OTC?: Over the Counter | YES NO | | YES NO | | | YES NO | | YES NO | |
| **MEDICATION** |  | |  | | |  | |  | |
| STRENGTH |  | |  | | |  | |  | |
| **METHOD**: Tablet, liquid, etc. |  | |  | | |  | |  | |
| AMOUNT/ FREQUENCY |  | |  | | |  | |  | |
| **EXACT TIME OF ADMINISTRATION** | AM | PM | AM | PM | | AM | PM | AM | PM |
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