

## FOSTER HOME INDIVIDUAL YOUTH MEDICATION LOG

State of Oregon OREGON YOUTH AUTHORITY

Foster Care Certifier Name:							Р	arole	)/Pro	batio	on O	Parole/Probation Officer Name:	r Na	me:									
Youth Name:		آ آ	JJIS#:	Ϊ.					Log Start	tart	Date:					_	Log End Date:	nd [	ate:				
Name & initials of person dispensing medication (please print):	on (plea	ise pr	int):										Sig	Signature: X	ıre:	× 							
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