State of Oregon
OREGON YOUTH AUTHORITY

FOSTER HOME INDIVIDUAL YOUTH MEDICATION LOG

Foster Care Certifier Name: ______________________ Parole/Probation Officer Name: ______________________

Youth Name: ______________________ JJIS # : ____________ Log Start Date: ____________ Log End Date: ____________

Name & initials of person dispensing medication (please print): ______________________ Signature: **X** ______________________

Name of Medication: **Dosage & Frequency:** **Prescribing Physician:**

Purpose:

Hour	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

Name of Medication: **Dosage & Frequency:** **Prescribing Physician:**

Purpose:

Hour	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

Name of Medication: **Dosage & Frequency:** **Prescribing Physician:**

Purpose:

Hour	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