Children's HOPE
Foster Family Agency
"Making a difference, one child at a time!"

COMPLETE AND SUBMIT EVERY MONTH

Client: _____ DOB: _____ Placement Date: _____

Resource Parent(s): _____ Month: _____ Year: _____

WEIGHT AND MEDICATION

WEIGHT

Date:	Weight:	Comments:

MEDICATION

List ALL medications and health supplements (vitamins, minerals, herbs, etc) stored for the client, even if they are not administered.

☐ Client does not have any medications or health supplements.

Medication/Supplement	*P	Strength	Qty	Expiration Date	Date Filled	# of Refills	Prescribing Physician and Phone Number	Pharmacy	Prescription #	**Given this month

*Check if this a psychotropic medication. Psychotropic medications include antidepressants, mood stabilizers, sedatives, antipsychotics, medications for dementia, psychostimulants and anti-anxiety agents. Sometimes psychotropic medications are prescribed for other reasons, like headaches or insomnia.
**Check if medication/supplement will be given this month. If checked, fill out a Medication Administration Record (MAR) at the time each dose of medication/supplement is given. Provide a copy of MAR to Children's Hope.

DESTROYED MEDICATION RECORD

Prescription medications which are not to be retained shall be destroyed by the representative and one other adult who is not a client.

Medication	Strength	Quantity Destroyed	Pharmacy	Prescription #	Disposal Date	Signature of Representative	Signature of Witness