NVFS SFC
MEDICATION QUESTIONNAIRE AND CONSENT

Youth Name: _____Date: ___/___/___D.O.B.: ___/___/___
Foster Family Name: _____
Medication ordered (name/form/strength/daily dosage/# prescribed):

Prescription #: _____
Beginning Date of Administration: ___/___/___Ending Date of Administration:___/___/___
Reason for Prescribed Medication:

Is this a controlled substance under the FDA?____yes____no

How much time should it take before desired effects can be expected to occur?

Special Instructions for Administration or Storage (e.g. take with meals, do not take with grapefruit juice, must be refrigerated, place drops in eyes):

Description of Common Side Effects to Look For/Risks/Alternatives:

Action to be Taken if Serious Side Effects Occur:

What should be done if a dosage is missed or vomited?

Follow-Up Instructions (Blood Tests, Examination, EKGs, etc.):

Are there any prescription or OTC medications that interact with this medication that should not be taken? If yes, list:

What OTC medications can be taken with this medication?

Prescribing Physician: _____ Phone:_____

Prescribing Physician Signature: _____ Date: _____

Your signature below indicates that the medication has been adequately explained to you, that you have had the opportunity to ask any questions, and that you authorize and consent to the administration of the medication(s) listed above. Your signature also indicates that you understand that, although you were given information regarding the most common side effects of this medication(s), there may be other side effects. You agree that you will promptly inform the doctor or SFC staff if there are any unexpected changes in the youth's condition, behavior, mood, or physical health.

Legal Guardian: _____ Date: _____
Signature (if youth is 13 years or younger)

Youth: _____ Date:_____
Signature (if youth is 14 years or older)

Foster Parent: _____ Date: _____
____ Signature