



Foster Family Agency
 "Our Children...
 Our Communities...
 Our Legacy..."

MEDICATION RELEASE FORM

Client Name: _____

PRESCRIPTION #	NAME OF MEDICATION	DOSAGE	QUANTITY RELEASED	QUANTITY RETURNED

MEDICATION RELEASE:

Date: _____ Time: _____

I am hereby releasing the above medication to _____ for the following period of time: From (Date) _____ To (Date) _____

Print Name: _____ Sign Name: _____

MEDICATION ACCEPTANCE:

Date: _____ Time: _____

I acknowledge receipt of the above-mentioned medication and agree to take responsibility to distribute the medication per the doctor's orders.

Print Name: _____ Sign Name: _____

MEDICATION RETURN:

Date: _____ Time: _____

I have received back into my possession the remainder of the above medications.

Print Name: _____ Sign Name: _____

Remember, all medication must be transported and kept in their original containers, and must be kept in a locked area in the foster home to which the child does not have access.

Under no circumstance is any foster child (regardless of age) to be allowed to dispense, transport, or take their own medication.

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