Bradford County Children & Youth Services
220 Main Street, Unit 1, Towanda, PA 18848
Telephone: 570-265-1760
Fax: 570-265-7066

MEDICATION LOG						
Name: **Known allergies:**					**Date:**	
Name of Medication	**Date Started**	**Dosage, Dosage Times**	**Refill Number**	**Pharmacy Name and Phone Number**	**Physician Name and Phone Number**	**Comments**

All medication and/or dosage changes must be approved by the guardian/caseworker. **(Revised 11-7-2013)**

Medical, Dental and Medication Record

Child's Name: _____
Birth Date: _____
Medical Plan: _____
MA Number: _____

Emergency Contact Name: _____
Address: _____
Phone: _____
Alternate Phone: _____

Medical/Dental/Vision Visits				
Date	**Nature of Visit**	**Attending Physician**	**Prescribed Medication**	**Diagnosis/Recommendations/Notes**

For each visit to a physician, health center, dentist or eye care, enter date (month/day/year), complete name of the provider, prescribed medications, if any, what was done and recommendations. All evasive treatment must be approved by guardian prior to procedure.

This form is to be given to the child's placement worker when requested and/or when the child leaves the foster home.
(Revised 11-7-2013)