Medication Evaluation

LIGHTHOUSE
Foster Care & Adoption Services

☐ Initial Medical ☐ Follow-Up ☐ Other: _____

Name of Child: _____

Date of Visit: _____ Time of Visit: _____

Doctor/PA: _____

Email: _____

Office Phone#: _____

Reason for Visit: _____

Current Medications & Dosage:

Medication	Dosage	Medication	Dosage

If Changes to Medication: ☐ Yes ☐ No

If yes: ☐ Increased ☐ Decreased ☐ Discontinued ☐ New Medication

Medication Name: _____ Dosage: _____ Frequency: _____

Reason Prescribed: _____

Medication Name: _____ Dosage: _____ Frequency: _____

Reason Prescribed: _____

Recommendation and Follow-Up: _____

_____

Please send all notes to LFCAS office email:

_____ _____

Foster Parent's Signature Date