THERAPEUTIC SERVICES AGENCY, INC.

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PRESCRIPTION INFORMATION

☐ **Therapeutic** ☐ **Non Therapeutic**

Client: _____

Name of Medication: _____

Dosage: _____

Prescribing Doctor: _____

Address: _____

_____

Phone #: _____

Date of Current Prescription: _____

Reevaluation Date: _____

Client Monitored or **Staff Monitored** (*Circle One)*

Additional Information Concerning Medication:

_____

_____

Purpose for Medication: _____

History of Medication (*How long have they been on medication?*)

Reminder to foster parents to keep all medications unaccessible to clients and give as needed.