NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

RESIDENT MEDICATION RECORD

RESIDENT'S NAME:	ALLERGIES:	PHYSICIAN'S NAME:	PHYSICIAN'S PHONE NO.:

MEDICATION	DATE PRESCRIBED	DOSAGE	FREQUENCY	TIME	METHOD	PRESCRIBING PHYSICIAN	PRECAUTIONS	ASSISTANCE REQUIRED*

*If resident needs supervision or assistance with medication, describe below and record assistance given on attached sheet, LDSS-3635.