MEDICATION ADMINISTRATION RECORD (MAR)

NOTE: This form should be used for all non-psychotropic medication.

Child's Name:	Date of Birth:	Sex:
Facility Name & Number or Foster/Certified/Resource Family Agency Name:		MO/YR:

Prescription Details	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Medication Name: Required Dosage: Time & Frequency of Dose: Quantity Prescribed: Prescription Filled Date: Prescription #: # of Refills:																																
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Medication Name: Required Dosage: Time & Frequency of Dose: Quantity Prescribed: Prescription Filled Date: Prescription #: # of Refills:																																

Allergies:

Monthly Weight & Date:

Anticipated Refill Date:

Pharmacy Name & Number:

Physician Name & Number:

Additional Instructions From Physician:

Placement Worker Name & Number:

Date and Description of Any Observed Side Effects:

A. Fill in what time the child takes the medication in the "TIME" column.
B. Put initials in appropriate box when medication is given.
C. Circle initials when not given.
D. State reason for refusal / omission on page 2 of 2.
E. PRN Medications. Reason given and results must be noted on page 2 of 2.
F. *S* = School; *H* = Home visit; *W* = Work; *P* = Program; *R* = Refusal; *O* = Other

MEDICATIONS NOT ADMINISTERED						Initials	Staff Signature
Date	Hour	Medication Name	Reason	Result			
					1		
					2		
					3		
					4		
					5		
					3		
					7		
					8		
					9		
					10		
					11		
Name:						MO / YR:	

All Staff/Caregivers please sign and initial below in order to identify initials

Signature	Initials	Signature	Initials	Signature	Initials

INSTRUCTIONS FOR LIC 622A – MEDICATION ADMINISTRATION RECORD (MAR)

.ecord onto the MAR immediately after each medication is self-administered by the child. This is the only way to be sure that the right medication was taken, by the right person, at the right time, by the right route. Refer to the MAR Legend for additional instructions with this form.

CHILD'S NAME
- Enter the full name of the child that will be taking the medication.

DATE OF BIRTH
- Enter the child's date of birth.

SEX
- Enter the biological sex (at birth) of the child that is listed in their file.

FACILITY NAME & NUMBER OR FOSTER/CERTIFIED/RESOURCE FAMILY AGENCY NAME
- Enter the name of the Licensed Community Care facility or home in which the child resides.

MO/YR
- Enter the month and year that the information in this log was documented.

PRESCRIPTION DETAILS
- Information for this section can be found on the label of the child's medication.
- This section is required to be filled out pursuant to Health and Safety Code section 1507.6(b)(2)(B)(i)-(vi).

TIME
- In the "Time" column should be the hour that the medication is to be taken. The numbers in the top row of this table reflect the days of the month. The adult filling out this MAR shall initial each box that corresponds with the appropriate date and time a child self-administers their medication. If a medication is not taken as prescribed for any reason, follow the instructions in the MAR Legend. Notify the appropriate person(s) of the missed medication according to your facility's or agency's policies.

ALLERGIES
- If the child is allergic to food, medication, etc., enter that information here

DATE AND DESCRIPTION OF ANY OBSERVED SIDE EFFECTS
- It is a best practice to monitor and document the children's reactions to their medication. If the child reports that he/she is experiencing side effects from a medication or if staff observes side effects or changes in behavior, staff should document the reported or observed side effects in this section.

MONTHLY WEIGHT & DATE
- It is a best practice to monitor and document the child's weight on a monthly basis. Enter the child's weight in this section and the date that the weight was taken.

ANTICIPATED REFILL DATE
- Information for this section can be determined by monitoring the number in the Quantity Prescribed section and the date that the child first began taking the medication. The facility or agency should have a policy in place to ensure timely requests for refills.
- Enter the date in which this medication will need to be refilled

PHARMACY NAME & NUMBER
- Enter the pharmacy's name and phone number. (This can be found on the pharmacy label of the medication.)

PHYSICIAN NAME & NUMBER
- Enter the prescribing physician's name and phone number in this section.

ADDITIONAL INSTRUCTIONS FROM PHYSICIAN
- Refer to the child's prescription for this information.

PLACEMENT WORKER NAME & NUMBER
- Enter the placement worker's name and phone number in this section. (Refer the child's file for this information.

MEDICATIONS NOT ADMINISTERED

DATE
- Enter the date that the medication was not self-administered as directed by the prescription.

HOUR
- Enter the time that the medication was not self-administered as directed by the prescription.

MEDICATION NAME
- Enter the name of the medication that was not self-administered as directed by the prescription.

REASON
- Explain the reason the medication was not self-administered as directed by the prescription.

RESULT
- Note any observed or reported behaviors or symptoms that may have resulted from the child's missed medication, (For instance: child became hyperactive, child became aggressive, child complained of a headache, etc.)

INITIALS
- Enter the initials of the caregiver/staff member who was supervising the child when the medication was missed.

STAFF SIGNATURE
- The caregiver/staff member who was supervising the child when the medication was missed will need to sign here.

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

I. CENTRALLY STORED MEDICATION

INSTRUCTIONS: *Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records for each client/resident shall be maintained for at least one year.*

Facility Name:

Facility Number:

Administrator:

Name: (Last First Middle)

Admission Date:

Attending Physician:

Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Date Started	Prescribing Physician	Prescription Number	No. of Refills	Name of Pharmacy

Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Date Started	Prescribing Physician	Prescription Number	No. of Refills	Name of Pharmacy

II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: *For facilities other than Residential Care Facilities for the Chronically Ill (RCFCI) and Residential Care Facilities for the Elderly (RCFE), prescription medication that is not taken with a client or resident when services are terminated or otherwise disposed of must be destroyed in the facility by the administrator or designated representative and witnessed by one other adult who is not a client or resident. Medication destruction records must be retained for at least one (1) year.*

*For **RCF-CIs:** Prescription medication that is not taken with a resident when placement is terminated or which is not to be retained must be destroyed by the administrator and the facility manager. Medication destruction records must be retained for at least three (3) years.*

*For **RCFEs:** Prescription medications which are not taken with a resident when services are terminated, not returned to the issuing pharmacy, not retained in the facility as ordered by the resident's physician and documented in the resident's record, not disposed of according to the established procedures of a hospice agency, or not otherwise disposed of must be destroyed by the administrator and one other adult who is not a resident of the RCFE, in the RCFE. Records documenting destruction of medication must be retained for at least three (3) years.*

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident

PSYCHOTROPIC MEDICATION ADMINISTRATION RECORD (MAR)

NOTE: Fill out a separate LIC 622B for each psychotropic medication the child is currently taking (HSC§ 1507.6[b][2][B].

Child's Name:	JV223 Date:	Date of Birth:	Sex:
Facility Name & Number or Foster/Certified/Resource Family Agency Name:			MO/YR:

Prescription Details	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Medication Name:																																
Required Dosage: Time & Frequency of Dose:																																
Quantity Prescribed: Prescription Filled Date: Prescription #: # of Refills:																																

Allergies:	Additional Instructions From Physician:
Date of Last Lab: / Anticipated Refill Date:	Date and Description Of Any Observed Side Effects:
Pharmacy Name & Number: / Physician Name & Number:	
Monthly Weight & Date:	A. Fill in what time the child takes the medication. B. Put initials in appropriate box when medication is given. C. Circle initials when not given. D. State reason for refusal / omission on page 2 of 2. E. *S* = School; *H* = Home visit; *W* = Work; *P* = Program; *R* = Refusal; *O* = Other.
Placement Worker Name & Number:	

HOME VISITS (Leaving)

Date	Name Of Medication	Quantity	Initials of Person Releasing Medication	Signature of Authorized Representative Receiving Medication

HOME VISITS (Returning)

Date	Name Of Medication	Quantity	Initials of Person Receiving Medication	Signature of Authorized Representative Releasing Medication

If psychotropic medication is prescribed, medication effectiveness and side-effects should be closely monitored according to the monitoring guidelines provided in the California Guidelines for Psychotropic Medication Use (Appendix B) in conjunction with the Prescribing Physician.

MEDICATIONS NOT ADMINISTERED						Initials	Staff Signature
Date	Hour	Medication Name	Reason	Result			
					1		
					2		
					3		
					4		
					5		
					6		
					7		
					8		
					9		
					10		
					11		
Name:						MO / YR:	

All Staff/Caregivers please sign and initial below in order to identify initials

Signature	Initials	Signature	Initials	Signature	Initials

'NSTRUCTIONS FOR LIC 622B – PSYCHOTROPIC MEDICATION ADMINISTRATION RECORD (MAR)

Record onto the MAR immediately after each medication is self-administered by the child. This is the only way to be sure that the right medication was taken, by the right person, at the right time, by the right route. Refer to the MAR Legend for additional instructions with this form.

Psychotropic medications shall be used only in accordance with the written directions of the physician prescribing the medication and as authorized by the juvenile court pursuant to Section 369.5 or 739.5 of the Welfare and Institutions Code (1507.6 (b)(1)).

CHILD'S NAME
- Enter the full name of the child that will be taking the medication.

JV-223 DATE
- This is the date in which the Court orders that the application requesting authorization to begin or continue taking psychotropic medication has been granted. (This date can be found on page 2 of the Order Regarding Application for Psychotropic Medication (JV-223)).

DATE OF BIRTH
- Enter the child's date of birth.

SEX
- Enter the biological sex (at birth) of the child that is listed in their file.

FACILITY NAME & NUMBER OR FOSTER/CERTIFIED/RESOURCE FAMILY AGENCY NAME
- Enter the name of the Licensed Community Care facility or home in which the child resides.

MO/YR
- Enter the month and year that this information in this log was documented.

PRESCRIPTION DETAILS
- Information for this section can be found on the label of the child's medication.
- This section is required to be filled out pursuant to Health and Safety Code section 1507.6(b)(2)(B)(i)-(vi).

TIME
- In the "Time" column should be the hour that the medication is to be taken. The numbers in the top row of this table reflect the days of the month. The adult filling out this MAR shall initial each box that corresponds with the appropriate date and time a child self-administers their medication. If a medication is not taken as prescribed for any reason, follow the instructions in the MAR Legend. Notify the appropriate person(s) of the missed medication according to your facility's or agency's policies.

ALLERGIES
- If the child is allergic to food, medication, etc., enter that information here.

ADDITIONAL INSTRUCTIONS FROM PHYSICIAN
- Refer to the child's prescription for this information.

DATE OF LAST LAB
- Information for this section may need to be obtained from the prescribing physician.

ANTICIPATED REFILL DATE
- Information for this section can be determined by monitoring the number in the Quantity Prescribed section and the date that the child first began taking the medication. The facility or agency should have a policy in place to ensure timely requests for refills.
- Enter the date in which this medication will need to be refilled.

DATE AND DESCRIPTION OF ANY OBSERVED SIDE EFFECTS
- It is a best practice to monitor and document the children's reactions to their medication. If the child reports that he/she is experiencing side effects from a medication or if staff observes side effects or changes in behavior, staff should document the reported or observed side effects in this section.

PHARMACY NAME & NUMBER
- Enter the pharmacy's name and phone number. (This can be found on the pharmacy label of the medication.)

PHYSICIAN NAME & NUMBER
- Enter the prescribing physician's name and phone number in this section.

MONTHLY WEIGHT & DATE
- It is a best practice to monitor and document the child's weight on a monthly basis. A child's weight may significantly fluctuate while taking psychotropic medication. Enter the child's weight in this section and the date that the weight was taken.

PLACEMENT WORKER NAME & NUMBER
- Enter the placement worker's name and phone number in this section. (Refer the child's file for this information.)

HOME VISITS (leaving)
This section should only be completed if applicable. Each time a child leaves on a home visit, the medications that are given to their authorized representative should be logged and accounted for. Ensure that the authorized representative knows who to contact if an incident occurs during the visit.

DATE
- Enter the date that the medication was given to the authorized representative.

NAME OF MEDICATION
- Enter each individual medication that is being released for the home visit.

QUANTITY
- Enter the medication count (number of pills) that is being given to the authorized representative for the home visit.

INITIALS OF PERSON RELEASING MEDICATION
- This section should be initialed by the person releasing the medication to the authorized representative for the home visit.

RECEIVED BY
- This section should be signed by the authorized representative receiving the medication.

HOME VISITS (returning)
Each time a child returns from a home visit, the medications should being given back to the facility, logged, and accounted for.

DATE
- Enter the date that the authorized representative returned upon the end of the home visit.

NAME OF MEDICATION
- Enter each individual medication that has been returned after the home visit.

QUANTITY
- Enter the medication count (number of pills) that has been returned after the home visit.

INITIALS OF PERSON RECEIVING MEDICATION
- This section should be initialed by the person receiving the medication from the authorized representative after the home visit.

RELEASED BY
- This section should be signed by the authorized representative once they have returned the medication after the home visit.

MEDICATIONS NOT ADMINISTERED

DATE
- Enter the date that the medication was not self-administered as directed by the prescription.

HOUR
- Enter the time that the medication was not self-administered as directed by the prescription.

MEDICATION NAME
- Enter the name of the medication that was not self-administered as directed by the prescription.

REASON
- Explain the reason the medication was not self-administered as directed by the prescription.

RESULT
- Note any observed or reported behaviors or symptoms that may have resulted from the child's missed medication, (For instance: child became hyperactive, child became aggressive, child complained of a headache, etc.)

INITIALS
- Enter the initials of the caregiver/staff member who was supervising the child when the medication was missed.

STAFF SIGNATURE
- The caregiver/staff member who was supervising the child when the medication was missed will need to sign here.

JV-220—Application for Psychotropic Medication

Who: Social Worker or Probation Officer (some counties may have PHN involved) provides to the Court

When: As soon as psychotropic medication is identified as a recommended part of a treatment plan.
Begins the process of applying to give or continuing to give psychotropic medication to a child or youth in foster care. It functions like a cover sheet for the full application, and must be accompanied by a completed and signed JV-220 (A) or (B) and thorough documentation before it is filed with the Court.

What: Provides the Court with

- information about the child and where he or she lives
- contact information for the social worker or probation officer of the case
- the input they have received from the child or caregiver about the medication plan, and
- their own input about the Application.
- history of other recent medications and/or treatments along
- information about who will be providing input and in what form
- social worker or probation officer verification that the information included in the attachments is accurate and complete

Attachments: Collateral Documents to provide context for the application (to be reviewed by prescribing Physician and by the Court)

- Detention Hearing Report—what happened and why child was removed from the home
- Jurisdiction/Disposition Report—history of abuse and/or neglect experienced by the child
- Any significant court documents or reports about family's situation
- Prior psychological evaluations and treatment plan documents
- Prior health records (mental health, physical health, developmental records)
- Information about any previous psychiatric hospitalizations
- Order Authorizing Health Assessments, Routine Health Care, and Release of Information (Blanket Court Order)
- History of Child Placement Report
- Health and Education Passport
- Individualized Education Plan and other relevant school records
- Medication Log, if applicable.

Where next: The SW or PO in charge of the case files the complete set of documents with the Court.