CAROLINA FAMILY CONNECTIONS

NAME: RECORD NUMBER:	The information listed below was explained to the client's guardian, on this date by CFC staff, his/her physician, pharmacist, social worker, or case manager (circle one) in a manner commensurate with their level of understanding and cognitive development.	
MEDICATION	PURPOSE	POTENTIAL SIDE EFFECTS

Signature of person furnishing the information to the client's guardian:

The information listed above was explained to me on this date to the best of my understanding. I know that if I have questions at any time, I can ask the Foster Care Case Manager or a physician. to help me get an answer. I understand that I will be notified of any changes in the medications listed above. This agreement expires one (1) year from date of signatures. I agree with the medication identified above.

Signature/Date: