MEDICATION ADMINISTRATION RECORD

Name: ______________________________ Month ____________ Year 20____

Allergies:

	Time	1	2	3	4	5	6	7	8	9	10	1	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Medication:																																
Dose:																																
Frequency:																																
Route:																																
MD:																																
Reason Prescribed:																																

	Time	1	2	3	4	5	6	7	8	9	10	1	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Initials ________ Signature ______________________ initials ________ Signature ______________________

Initials ________ Signature ______________________ initials ________ Signature ______________________

ATTACH MED ORDERS FOR ALL NEW AND RENEWED PRESCRIPTIONS!

NOTE: NON-PRESCRIPTION M ICATION ON REVERSE

NON-PRESCRIPTION MEDICATIONS

(Medication must be on Approved Non-Prescription List or Prescribed by Physician)

Date	Time (AM/PM)	Medication	Dose	Reason Given	Initials