Medication Administration Records

Individual Name:_____ Program Name:_____
Medication Name:_____ Medication Type:_____
Month:_____ Year:_____
Dose Form: _____
☐ Administered ☐ Not Administered

Note: If the 'Record Type' differs from the above two you may fill in the boxes with the required initials from below.
M - Missed **R** - Refused **LOA** - Leave of Absence **OH** - On Hold **D** - Deleted

Drug Details:

Strength:_____ Give Amount/Quantity:_____ Measurement Unit:_____ Route:_____
Frequency:_____ Begin Date & Time:_____ End Date & Time:_____
Schedule Repeat:_____ Schedule Weekdays:_____ Schedule Time Slot(s):_____
Prescriber:_____

Day/ 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

Indication/ Purpose:_____
Instruction/ Comments:_____
Administered By:_____Signature:_____Initials:_____ Date:_____Time:_____am/pm
Administered By:_____Signature:_____Initials:_____ Date:_____Time:_____am/pm
Administered By:_____Signature:_____Initials:_____ Date:_____Time:_____am/pm
Administered By:_____Signature:_____Initials:_____ Date:_____Time:_____am/pm
Administered By:_____Signature:_____Initials:_____ Date:_____Time:_____am/pm
Administered By:_____Signature:_____Initials:_____ Date:_____Time:_____am/pm

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

© Therap Services, LLC, 2003 – 2016. All Rights Reserved. Last Updated: April 2016