



MEDICATION ADMINISTRATION RECORD

Month/Year:	Client Name:	DOB:
	Address:	Phone:

Medication/Dose/Route/Frequency	Date/Time									Comments/Special Instructions
	Set Time:									
	Actual time:									
	Staff Initials:									
	Set Time:									
	Actual time:									
	Staff Initials:									
	Set Time:									
	Actual time:									
	Staff Initials:									
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									IN:	OUT:
	Set Time:									
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	Actual time:									
	Staff Initials:									
	Set Time:									
	Actual time:									
	Staff Initials:									
									IN:	OUT:

Legend: 1 = Refused 2 = LOA 3 = Home 4 = Other:See Chart

Allergies:	Last BM:	Weight:	PARENT Signature:	1. NURSE Signature:	2. NURSE Signature:
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