MEDICATION ADMINISTRATION

Name: | Month: | Year: | Self Administers: ☐ Yes ☐ No

medication/dosage	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
Drug:																																
Dosage:																																
route:																																
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LIST ANY ALLERGIES, ADVERSE REACTIONS TO MEDICATIONS:

TIME ABBREVIATIONS: hr of sleep = hs; Daily = qd; 2 x day = bid; 3 x day = tid; 4 x day = quid

Staff Signature	Initials

Staff Signature	Initials

Staff Signature	Initials

P.R.N. MEDICATION RECORD

Client Name: _____

Date:	Time:	Medication & Reason Given:	Results:	Initials

MEDICATION DISPOSAL

(For unused, discontinued, outdated, recalled, or contaminated medications)

Date of disposal:	Medication & Strength:	Amount Disposed of:	Reason for Disposal:	Method of Disposal:	Signature of person disposing:	Signature of witness: (Required for Controlled Substances)