MEDICATION ADMINISTRATION RECORD

Name: ____ DOB: __________ Month _____________ Year 20____

Allergies:

Guardian name: Guardian phone:

	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 __________________________

Note PRNs and medication errors on reverse

PRNs and Medication Errors

Date	Time	Initials	Medication	Dose	Explanation	Result

	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
Temp.																															
Pulse																															
Resp.																															
Blood Press.																															
Weight																															