



## Medication Count Form

*Medication, Dosage, and Label Instruction:*

<b>Medication Name/Dosage:</b>			<b>Medication Side Effects:</b>		
<b>Participant's Name:</b>			<b>Month/Year:</b>		
<b>Beginning of Shift</b>			<b>End of Shift</b>		
<b>Date/Time</b>	<b>Signature</b>	<b>Count</b>	<b>Date/Time</b>	<b>Signature</b>	<b>Count</b>

**\*\* MED COUNTS NEED TO BE CONDUCTED AT THE START AND END OF EVERY SHIFT.  
 \*\* NEXT STAFF COMING IN SIGNS TO VERIFY THE COUNT.**

<b>Beginning of Shift</b>			<b>End of Shift</b>		
<b>Date/Time</b>	<b>Signature</b>	<b>Count</b>	<b>Date/Time</b>	<b>Signature</b>	<b>Count</b>

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