



MEDICATION RECORD

PARTICIPANTS NAME: _____ MONTH: _____ YEAR _____ ALLERGIES: _____

MEDICATION	Dose	Hour Given	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	
VERIFICATION INITIALS																																		

REASON MEDICATION WAS NOT GIVEN OR GIVEN AT A DIFFERENT TIME:

DATE: _____ TIME: _____ MEDICATION: _____

STATEMENT WITH SIGNATURE: _____

DATE: _____ TIME: _____ MEDICATION: _____

STATEMENT WITH SIGNATURE: _____

PARTICIPANTS NAME: _____

OBSERVED MEDICATION REACTIONS:

DATE: _____ TIME: _____ MEDICATION: _____

STATEMENT WITH SIGNATURE: _____

DATE: _____ TIME: _____ MEDICATION: _____

STATEMENT WITH SIGNATURE: _____

MEDICATIONAL DISCONTINUATIONS (STATE MEDICATION DOSAGE; PHYSICIAN WHO ORDERED, PHYSICIAN WHO DISCONTINUED AND DATE DISCONTINUED)

DATE: _____ TIME: _____ MEDICATION: _____ SIGNATURE: _____ INITIALS: _____

MEDICATION ERRORS (STATE NATURE AND REASON FOR ERROR): _____

DATE: _____ TIME: _____ MEDICATION: _____ SIGNATURE: _____ INITIALS: _____

MEDICATION ERRORS (STATE NATURE AND REASON FOR ERROR): _____

STAFF AUTHORIZED TO DISPENSE MEDICATION:

PRINTED STAFF NAME SIGNATURE TITLE INITIALS

PRINTED STAFF NAME SIGNATURE TITLE INITIALS

PRINTED STAFF NAME SIGNATURE TITLE INITIALS

MEDICATION ERRORS (State nature and reason for error)

STAFF DESIGNED TO VERIFY MEDICATION WAS DISPENSED:

Date Time Medication

Printed Name Signature Title Initials