MEDICATION ADMINISTRATION RECORD

Name	Unit/Cabin	Allergies	Physician Phone#

Staff Responsible	Session/Dates	Parent(s) Phone #

SCHEDULED MEDICATIONS

Medication (Name, Dose, Route, Frequency)	Date/ Hour													

	Initials	Full Signature		Initials	Full Signature
1			4		
2			5		
3			6		

Name	Unit	Allergies	Unit Staff

PRN and ONE-TIME MEDICATIONS

MEDICATION (Dose, Route, Frequency)	Reason for Med	Date, Time, and Initials								Effects Noted

DOCUMENTATION of OMITTED DOSE of MEDICATION

MEDICATION (Dose, Route, Frequency)	Dose Omitted	Reason for Omission	Initials