Sample form

Medication Administration Record

School _____

Student Name: _____ DOB: ___/___/___ Rm/Program_____ Prescriber: _____

For any unusual circumstance, circle you initials and write a comment on the back of the sheet.
Be sure to include the date, the time, and the medication(s) involved. Month/Year: _____

MEDICATIONS	HOUR	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
Supervision of medication compliance																																

Recording Codes:

(A) Absent; **(O)** No Show; **(E)** Early Dismissal; **(W)** Dosage Withheld; **(F)** Field Trip;
(X) No School (e.g., holiday, snow day); **(N)** No Medication Available

Adapted from "Assisted Living Home Care Manual for Provider An Educational Tool, Minnesota Department of Health, July 1999.

Sample form

STAFF NAME AND TITLE	INITIALS	STAFF NAME AND TITLE	INITIALS

Special Remarks
(Be sure to Sign Your Entry)

DATE	TIME	MEDICATION(S)	