

Medication Administration Record

MO/YR:	Start/Stop Date	Facility Name:																															
Medication	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	
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Diagnosis:	DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)	Comments
Allergies:	Physician Name	A. Put initials in appropriate box when medication is given. B. Circle initials when not given. C. State reason for refusal / omission on back of form. D. PRN Medications: Reason given and results must be noted on back of form. E. Legend: S = School; H = Home visit; W = Work; P = Program.
	Phone Number	
NAME:		
Record #	Date of Birth:	
	Sex:	