MEDICATION ADMINISTRATION RECORD

Month/Year: _____

PATIENT NAME
DATE OF BIRTH
ID / ROOM NO.

ALLERGIES
DIAGNOSIS / PRIMARY PHYSICIAN

MEDICATION NAME	DOSAGE	ROUTE	FREQUENCY	TIME/DATE VERIFICATION	INITIALS

PRN / NURSING NOTES
STAFF SIGNATURE KEY

Initials: _____ Signature: _____

Initials: _____ Signature: _____

Initials: _____ Signature: _____