Record of Medication Administration

Name _____ Birthdate _____

Medication _____ Dosage _____

Time of administration _____ # of pills/dose _____

# of pills received _____	Date: _____	Expires _____	Initial _____
# of pills received _____	Date: _____	Expires _____	Initial _____
# of pills received _____	Date: _____	Expires _____	Initial _____
# of pills received _____	Date: _____	Expires _____	Initial _____
# of pills received _____	Date: _____	Expires _____	Initial _____
# of pills received _____	Date: _____	Expires _____	Initial _____

Date	Time	Given by	Comment	Date	Time	Given by	Comment

NOTE: Please attach Physician/Dentist Request form (3416 F1) to the back of this form.