# SAMPLE Medication Administration Record

Name of Person:_____ Date of Birth: _____ Gender:_____ Allergies: _____

Address: _____ State:_____ ZIP: _____ Home Phone: _____

Insurance Provider and Number: _____ Primary Heath Care Professional: _____ Phone:_____

| Medication (Strength, Dose, Form, Route, and Special Directions) | Time | Month and Year:_____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | 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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| # | Initials | Signature |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

**Initials in box** means meds given as recommended.
If any symbol is used, a note must be made regarding the situation in the medical narrative.
**H/Initials**-Hold medication as ordered by medical professional
**R/Initials**- Medication was refused by the person (R = refused)
**L/Initials-** Medication packaged for individual to take away from home (L = leave)
**Circled initials-** medication error

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