Medication Administration Record

Patient: ______________________ Physician: ______________________ Year :__________

Allergies: ______________________ Admission Date: ______________ ID # ____________

Standing Orders	Times	Date						
	↓	/	/	/	/	/	/	/

PRN Medications – Write the date, time given and initials inside the box for each dosage given.

Name ______________________ Signature ______________________ Initials: __________

Name ______________________ Signature ______________________ Initials: __________

Name ______________________ Signature ______________________ Initials: __________

Name ______________________ Signature ______________________ Initials: __________