PRN

MEDICATION ADMINISTRATION RECORD

client label

Initial Co-Sign	Drug, Dose, Frequency, Route & Indications for Use	DATE													
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
/															
/															
/															
/															
/															

I certify that I have given the above medication administration directions to designated nursing staff. ______________________________

Parent / Guardian Signature

Initials	Staff Name	Staff Signature