SCHEDULED
MEDICATION ADMINISTRATION RECORD

client label

Initial Co-Sign	Drug, Dose, Frequency, Route	TIMES	DATE							
/										
/										
/										
/										
/										

Initial Co-Sign	Drug, Dose, Frequency, Route	TIMES	DATE							
/										
/										
/										
/										

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

Parent / Guardian Signature & Initial

Initials	Staff Name	Staff Signature