Medication Administration Record

History of Drug Allergies:

Name of resident _____ Date of birth _____ Bed no. _____ Month Year

Date of prescription	name, formulation and dosage of drug	Frequency of use	Time of use	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
		time(s) a day	am																															
		tablet(s)each time	am																															
prepare / check			pm																															
	Source of drug		pm																															
				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
		time(s) a day	am																															
		tablet(s)each time	am																															
prepare / check			pm																															
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		time(s) a day	am																															
		tablet(s)each time	am																															
prepare / check			pm																															
	Source of drug		pm																															
				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
		time(s) a day	am																															
		tablet(s)each time	am																															
prepare / check			pm																															
	Source of drug		pm																															
				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
		time(s) a day	am																															
		tablet(s)each time	am																															
prepare / check			pm																															
	Source of drug		pm																															
	Signature for drug giving record Signed = drug taken; H = returned home; A = admitted to hospital; R = refuse to use one or more drugs; O = others Note: For "R" or "O", please inform the nurses / health workers for follow-up and it should be recorded properly. Date of prescription = the date on which the drug has been prescribed for use for the first time.		am																														
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