1. 5 Sample Medication Administration Form

| Name: | |  | | | Medicare No: | |  | | | Month: | |  | |
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|  | |  | | |  | |  | | |  | |  | |
| **Date** | **AM medication and dose** | | **LUNCH medication and dose** | **PM medication and dose** | | **Signature of staff administering medication** | | **PRN medication and dose** | **Reason for PRN** | | **Resident’s response to PRN** | | **Signature of staff administering PRN medication** |
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Record of staff signature

| **Name** | **Signature/Initials** |
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