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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