Medication Administration Record

Long-Term Care Example

Resident Name		**Room#**	
Date of Birth		**Month/Year**	
Physician		**Allergies**	

Medication Name & Dosage	Route	Frequency	Day of the Month																														Time	Initia
			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		

Notes / Special Instructions:

Nurse/Staff Name	**Initials**	**Signature**	**Date**