Daily Medication Administration Record

Resident Name:

Room/Bed:

Date of Birth:

Month/Year:

Physician:

Medication Name & Strength	Dosage	Route	Time	Day of Week							Initials	Comments
				Sun	Mon	Tue	Wed	Thu	Fri	Sat		

PRN Medications (As Needed):

Administered By (Nurse/Staff):

Date:

Verified By: