DHS
Oregon Department of Human Services
Seniors and People With Disabilities

Medication Administration Record for PRN'S

Resident: _____ Physician: _____

Date	Hour	Medication	Reason	Results	Hour

Instructions				Initials		Signature
A. Write initials in appropriate box at the time medication is given.				1		
B. Circle initials when medication is refused.				2		
C. State reason for refusal in the narrative.				3		
D. State reasons PRN is given, and the results.				4		
E. Date and initial all changes.				5		

Medication Administration/Instruction Record

Resident: _____ Physician: _____

Month/Year: _____ Allergies: _____

Medication	Hour	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
Medication	Hour	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

Initials	Signature	Initials	Signature
Initials	Signature	Initials	Signature