Department of Health and Human Services
Disability Services

MEDICATION ADMINISTRATION RECORD

(SHORT TERM, LONG TERM)

PAGE:	OF:

CLIENT'S NAME:

ADDRESS:

DATE OF BIRTH: **SEX:**

ORGANISATION:

SERVICE:

DRUG SENSITIVITIES:

Generic Name:	Commence Date:	Dose:	Date:
Trade Name:	**Cease Date:**	**Frequency:**	**Dr's Signature:**

Month	Time	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

Generic Name:	Commence Date:	Dose:	Date:
Trade Name:	**Cease Date:**	**Frequency:**	**Dr's Signature:**

Month	Time	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

PRESCRIPTIONS MUST BE PRINTED AND SIGNED BY THE DOCTOR

Generic Name:	Commence Date:	Dose:	Date:
Trade Name:	Cease Date:	Frequency:	Dr’s Signature:

Month	Time	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

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