Choices In Community Living, Inc.

Non-Staff Medication Administration Record

Name:_____ **Year:**_____

Time	Medication Name	Dosage	Purpose	Method of Admin./ Route	Special Instructions	Date														
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The directions and use of these medications were explained to me, and I understand how to administer these medications. The staff has answered any of my questions.

_____ Signature of Responsible Party/Parent/Guardian _____ Date _____ Signature of Staff Explaining Medications _____ Date

_____ Signature of Staff **Receiving Returned Medications** _____ Date