St. Clair County Mental Health

Medication Administration Record

Individual: ____________________ Home: ____________________

Allergies: ____________________ Others: ____________________

Month: _________ Year: _________ Case #: ____________________

MEDICATION START & STOP DATES	Hr.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
STANDING MED. ORDERS	Hr.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

SIGNATURE AND INITIALS OF EACH PERSON SIGNING ABOVE:

Health-Medical Form: #04-0048
Reviewed Date: 7/1/2024
Policy Ref: #04-001-0005, #04-001-0045, #04-001-0050, #04-003-0035, #04-003-0075, #04-003-0090
EHR: Health Services, Other Health Documents Note: MAR (Month Year)

O - With employee initials inside when omitted or held.		
P - Program	A - Absent	H - Holiday
N - No Program	S - School	W/E - Weekend
R - Refused	V - Visit	I – Inpatient /Hospital
NMS - No Meds Sent		

MEDICATION ADMINISTRATION RECORD

INDIVIDUAL:____________________________

CASE #:________________________________

ALLERGIES: ____________________________

____

MONTH:_____________YEAR:__________

MEDICATION START & STOP DATES	Hr.	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
STANDING MED. ORDERS	Hr.	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

SIGNATURE AND INITIALS OF EACH PERSON SIGNING ABOVE:

Health-Medical Form: #04-0048
Reviewed Date: 7/1/2024
Policy Ref: #04-001-0005, #04-001-0045, #04-001-0050, #04-003-0035, #04-003-0075, #04-003-0090
EHR: Health Services, Other Health Documents Note: MAR (Month Year)