

Consumer Name: _____

Medical Sign-Off

Allergies:

Attending Physician: _____

ID #: _____ DOB: _____

Emergency Number(s): 290-3498
324-6900 / 6901 (CCS)

Month: _____ Year: _____

	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						
Medication																																						
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Staff Init _____ = Staff Name _____ Staff Init _____ = Staff Name _____

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See Reverse Side to list All PRN Medications and/or Over the Counter Medications

A Clear Order must be obtained for PRN's and Over the counter Med's

PRN & OVER-THE-COUNTER MEDICATIONS

NAME: _____ DOB _____

A Clear Doctors order **must** be received by the doctor directing:

- When to administer (Including the direct order. Example.- 2 x 250 mg Tylenol pills orally For fever- every 4 hrs until temperature reduced to 98.6 and for no more than 16 hrs or a total of 15- 250mg Tylenol.)

Date	Time	Medication	Dosage	Reason	Affect

Medication Error Section

You **must** write an incident report for missed medications.

Date	Medication	Dosage	Time	Reason for error	Physician Instruction

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