Respite Connection Medication Administration Record *This form is to be turned in with your notes

Consumer's Name: _____ **Medicaid #:** _____ **Date of Birth:** _____

Parent/Guardian Signature (authorizing staff to give these medictions): _____

Staff Signature : _____ **Staff Printed Name:** _____

(MM/DD/YY)		Strength & Amount: (ex.160mg, 2 tabs)	·Oral ·G/J-Tube ·Nasal ·Topical ·Rectal ·Inhaled ·Injection ·Eye/Ear drop ·Vaginal	Include AM or PM	Include AM or PM	Include AM or PM	Include AM or PM
Date:	**Name of Medication:**	**Dose:**	**Route:**	**Time Given:**	**Time Given:**	**Time Given:**	**Time Given:**

Special instructions to note:

_____