True Friends Health Care - Medication Administration Record - Page 1

TRUE FRIENDS
Camps. Respite. Programs. Travel.

Form Instructions: Please fill out the form below per the examples given. All greyed out boxes and text are for staff use only.

Name: Age/DOB: Session:

Medication Name & Strength (E.g. Ibuprofen 500mg)	Quantity (E.g. # of pills/ drops/sprays)	Frequency (E.g. 2x/day)	Route	Reason/Comments (E.g. I take it for headaches)	Dispensation (E.g. What time(s) during the day?)	See HC Notes	Date 2020							
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									

True Friends Health Care - Medication Administration Record - Page 2

TRUE FRIENDS
Camps. Respite. Programs. Travel.

Form Instructions: Please fill out the form below per the examples given. All greyed out boxes and text are for staff use only.

Name: Age/DOB: Session:

Medication Name & Strength (E.g. Ibuprofen 500mg)	Quantity (E.g. # of pills/ drops/sprays)	Frequency (E.g. 2x/day)	Route	Reason/Comments (E.g. I take it for headaches)	Dispensation (E.g. What time(s) during the day?)	See HC Notes	Date 2020							
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									
		Select...	Select...		☐ 8 a.m. (AM) ☐ 2:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)									

True Friends Health Care - Medication Administration Record - Page 3

TRUE FRIENDS
Camps. Respite. Programs. Travel.

Form Instructions: Please fill out the form below per the examples given. All greyed out boxes and text are for staff use only.

Name: Age/DOB: Session:

Medication Name & Strength (E.g. Ibuprofen 500mg)	Quantity (E.g. # of pills/ drops/sprays)	Frequency (E.g. 2x/day)	Route	Reason/Comments (E.g. I take it for headaches)	Dispensation (E.g. What time(s) during the day?)	See HC Notes	Date 2020							
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											

Print Name	Signature	Initials	Credentials

X Responsible Party Signature: I have pre-filled my participants medications and I give True Friends staff permission to administer the medications as they have been prepared.

True Friends Health Care - As Needed/PRN Medication List - Page 4

TRUE FRIENDS
Camps. Respite. Programs. Travel.

Form Instructions: Please fill out the form below per the examples given. All greyed out boxes and text are for staff use only.

Name: Age/DOB: Session:

Medication Name & Strength (E.g. Ibuprofen 500mg)	Quantity (E.g. # of pills/ drops/sprays)	Frequency (E.g. 2x/day)	Route	Reason/Comments (E.g. I take it for headaches)	Dispensation (E.g. What time(s) during the day?)	See HC Notes	Date 2020							
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											

True Friends Health Care - As Needed/PRN Medication List - Page 5

TRUE FRIENDS
Camps. Respite. Programs. Travel.

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Name: Age/DOB: Session:

Medication Name & Strength (E.g. Ibuprofen 500mg)	Quantity (E.g. # of pills/ drops/sprays)	Frequency (E.g. 2x/day)	Route	Reason/Comments (E.g. I take it for headaches)	Dispensation (E.g. What time(s) during the day?)	See HC Notes	Date 2020							
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											
		Select...	Select...											

Print Name	Signature	Initials	Credentials

X Responsible Party Signature: I have pre-filled my participants medications and I give True Friends staff permission to administer the medications as they have been prepared.