TRUE FRIENDS
Camps. Respite. Programs. Travel.

True Friends Health Care
Medication Administration Record Form

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)	Dispensation (E.g. What time(s) during the day?)	Route	Reason/Comments (E.g. I take it for headaches)	See HC Notes	Date 2021-22							
			8 a.m. (AM)				8 a.m. (AM)							
			12:30 p.m.(AFT)				12:30 p.m.(AFT)							
			5:30 p.m. (PM)				5:30 p.m. (PM)							
			8:30 p.m. (HS)				8:30 p.m. (HS)							
			8 a.m. (AM)				8 a.m. (AM)							
			12:30 p.m.(AFT)				12:30 p.m.(AFT)							
			5:30 p.m. (PM)				5:30 p.m. (PM)							
			8:30 p.m. (HS)				8:30 p.m. (HS)							
			8 a.m. (AM)				8 a.m. (AM)							
			12:30 p.m.(AFT)				12:30 p.m.(AFT)							
			5:30 p.m. (PM)				5:30 p.m. (PM)							
			8:30 p.m. (HS)				8:30 p.m. (HS)							
			8 a.m. (AM)				8 a.m. (AM)							
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			8 a.m. (AM)				8 a.m. (AM)							
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			8:30 p.m. (HS)				8:30 p.m. (HS)							
			8 a.m. (AM)				8 a.m. (AM)							
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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.

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