TRUE FRIENDS
Camps. Respite. Programs. Travel.

True Friends Health Care
Medication Administration Record

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)	Administration (E.g. What time(s) during the day?)	See HC Notes	2021-22	Friday	Saturday	Sunday
							Date			
		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)					
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					8:30 p.m. (HS)					
		Select...	Select...		8 a.m. (AM)					
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		Select...	Select...		8 a.m. (AM)					
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		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)					
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		Select...	Select...		☐ 8 a.m. (AM) ☐ 12:30 p.m.(AFT) ☐ 5:30 p.m. (PM) ☐ 8:30 p.m. (HS)					
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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.

TRUE FRIENDS
Camps. Respite. Programs. Travel.

True Friends Health Care Medication Administration Record/PRN As Needed

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Name:

Age/DOB:

Session:

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		Select...	Select...		8 a.m. (AM) 12:30 p.m.(AFT) 5:30 p.m. (PM) 8:30 p.m. (HS)					
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True Friends Health Care
Medication Administration Record
PRN/As Needed

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