Human Resource Training

MEDICATION ADMINISTRATION CHART

Individual's Name: _____ **HRT Provider's Name:** _____ **Month/Yr:** _____

Known Allergies: **Pharmacy Name:** **Pharmacy #:**

Dates→	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: _____ _____ **Dose:** _____ **Route:** _____ **Used For:** _____																																
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Dates→	**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**

PCP Name/Number: _____ / _____ **Value Options Nurse Name/Number:** _____ / _____

Print/Sign/Initial: _____ / _____ / _____ **Prescription Copy: Yes ___ No ___ N/A ___new Script: Yes ___ No ___**

Print/Sign/Initial: _____ / _____ / _____

Print/Sign/Initial: _____ / _____ / _____

Key: **H** = Home with Family **D** = Day Program / School
R = Respite **O** = Other (Explain "other" on back of chart)

Individual's Name: _____ **HRT Provider's Name:** _____ **Month/Yr:** _____

MEDICATION ERRORS / REFUSALS

In the case of a medication error:
Call the doctor or pharmacy listed on the prescription bottle.
Write down what instructions you are given.
Obtain the identifying information of the person instructing you.
Report the error to appropriate persons: State, HRT & Parent/Guardian.
Document on medication chart.

In the case of a serious medication side effect:
Call 911 immediately.
Follow and write instructions.
***If you are told to monitor, be sure you know what changes you are watching for.**
Notify Parent/Guardian, State and HRT immediately.

Date of Error/Refusal	Doctor/Nurse/Pharmacist Recommendations	Time/Date HRT Informed	HRT Contact

MEDICATION CHANGES / CONCERNS / ALLERGIC REACTIONS

Date	Concern, Allergic Reaction, Medication Changes, Follow-Up Needed	Date / Person Reported To

OVER THE COUNTER MEDICATION ADMINISTRATION

Date	Time	Medication	Dose	Reason Given	Results	Provider Signature