[Insert organisation name/logo]

# CLIENT MEDICATION RECORD

***🖌Note\****

*All client medication administration templates should be reviewed by qualified medical personnel before finalising.*

*\*Please delete note before finalising this template.*

This form is used to record all client prescribed non – PRN medications. Only staff authorised to administer medications are to complete this form, see the Medication Administration Authorisation Sheet for more information.

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| --- | --- | --- | --- |
| **Client name** |  | **Client ID** |  |

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| --- |
| **Known Allergies** |
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|  |  |
| --- | --- |
| **Medication One :** |  |
| **Strength:** |  | **Dose:** |  |
| **Route of administration:** |  | **Timing:** |  |
|  | **Date** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** |
| **MON** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **TUES** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **WED** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **THURS** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FRI** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SAT** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SUN** |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Medication Two :** |  |
| **Strength:** |  | **Dose:** |  |
| **Route of administration:** |  | **Timing:** |  |
|  | **Date** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** |
| **MON** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **TUES** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **WED** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **THURS** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FRI** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SAT** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SUN** |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Medication Three :** |  |
| **Strength:** |  | **Dose:** |  |
| **Route of administration:** |  | **Timing:** |  |
|  | **Date** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** | **Time**  | **Staff Signature** | **Client Signature** |
| **MON** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **TUES** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **WED** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **THURS** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FRI** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SAT** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **SUN** |  |  |  |  |  |  |  |  |  |  |  |  |  |