CK FAMILY SERVICES PRESCRIPTION MEDICATION LOG

Month/Year _____

Patient's Name _____ Physician's Name _____

Name & Strength of Drug _____ Amount Received _____

Reason for the Medication _____ Medication Allergies _____

Directions/Dosage _____

Signature of Person Administering Medication	Date	Time Given	Amount Given	Signature of Person Administering Medication	Date	Time Given	Amount Given

**If medication is not given as prescribed, please explain circumstance on separate page and attach to log

**Person administering medication must sign name initially and then initials may be used. Additional individuals administering must sign full signature and then use initials.

Printed Name _____ Signature _____ Initials _____

Printed Name _____ Signature _____ Initials _____