DPP-106H
(R. 11/11)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services

Medication Administration Form

For _____(MONTH) of_____(YEAR)

Child's Name: _____ DOB:_____ Height:_____ Weight: _____ Med. Allergy/Reaction_____

EACH time you give a child their medication please remember the "Six Rights of Medication Administration"
1. Right Person 2. Right Medication 3. Right Dosage 4. Right Route 5. Right Time 6. Right Documentation

Medication 1 Details	Time Given	Day (initial the box as medication is given)																													
		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:																																
For:																																
Refill Date:																																

Medication 2 Details	Time Given	Day (initial the box as medication is given)																													
		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:																																
For:																																
Refill Date:																																

Medication 3 Details	Time Given	Day (initial the box as medication is given)																													
		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:																																
For:																																
Refill Date:																																

File: Original in Passport;
Copy in Professional Section

Your Initials = Med Taken Your Initials + R=Med refused Your Initials + M= Med Missed
* Document on a separate page and notify physician and family social services worker that day.

OVER ➡

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For _____(MONTH) of_____(YEAR)

Medication 4 Details	Time Given	Day (initial the box as medication is given)																													
		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:																																
For:																																
Refill Date:																																

Medication 5 Details	Time Given	Day (initial the box as medication is given)																													
		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:																																
For:																																
Refill Date:																																

Your Initials = Med Taken Your Initials + R=Med refused Your Initials + M= Med Missed
* Document on a separate page and notify physician and family social services worker that day.

Resource Parent Signature: _____ Date _____

Disposal of unused or expired medication: *(Do not flush the meds or pour down a drain)*

Amount disposed of _____ (oz tablets capsules)

Method _____

By (Please Print)_____ Signature _____ Date _____

Witness (please Print) _____ Signature _____ Date _____

File: Original in Passport;
Copy in Professional Section