DPP-106H (R. 11/11)

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

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| | | | | Medication Administration For | | | | | | | | | | | | | | | (MONTH) of | | | | | | | | (YEAR) | | | | | |
| d's Name | : | | | | | | | | | [| OOB: | | | H | leigh | nt: | | v | Veig | ht: _ | | | Med. Allergy/Reaction | | | | | | | | | _ |
| | | FΑ | CH t | ime | VOL | give | - a c | hild | thei | ir me | -dica | ation | n ple | ase | rem | emb | er t | he " | Six F | Right | ts of | Me | dica | tion | Adr | nini | strat | tion' | , | | 7 | |
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| term bate. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | L |
| Medication | Time | | | | | | | | | | | Ι | Day (| initia | al the | box | as r | nedi | catio | n is | givei | 1) | | | | | | | | | | |
| 2 Details | 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 | 3 |
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| Medication 3 | Time | Day (initial the box as medication is given) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Details | 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 | 3 |
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| Refill Date: | | | | | 1 | 1 | | 1 | 1 | 1 | | | 1 | | | | | | | | | | | | | | | | 1 | | 1 | 1 |

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.

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

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:TOT Dose: :noitsoib9M Details Given 9٤ LL OL 31 30 56 74 52 | 23 12 70 18 ٩l ħί 15 Day (initial the box as medication is given) Medication Refill Date: :TOT Dose: :noitsoib9M Given Details 74 52 23 18 L١ 9٤ 31 30 12 ٩l ħι 15 LL OL Day (initial the box as medication is given) Medication (YEAR) _îo (HTNOM)_ For Medication Administration Form

 $\label{eq:first} Your\ Initials = Med\ Taken \qquad Your\ Initials + R=Med\ refused \qquad Your\ Initials + M=\ Med\ Missed \\ *\ Document on a separate page and notify physician and family social services worker that day.$

Date .

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

Method

By (Please Print)

Signature

Signature

Date

Date

Date

Date

Date

Date

Date

Date

Date

File: Original in Passport; Copy in Professional Section

Resource Parent Signature:

Refill Date: