

MEDICATION ADMINISTRATION FORM

Date _____ Agency/Unit Name/Location _____

Incident # _____ Dispatch Time _____

Pt. Age/Gender _____ Pt. DOB _____ Pt. Weight in Kg _____

Assessment Time: _____ LOR _____ Pulse _____ SaO2 _____
RR _____ Breath Sounds _____ BP _____

Reason for Medication Administration:

PREVIOUS MEDICAL HISTORY:

A _____
M _____
P _____
L _____
E _____

MEDICATION ADMINISTRATION:

Med: _____ Dose Administered _____
Concentration _____ Expiration Date _____
Route/Loc of Admin: _____
Pt. Response: _____

REASSESSMENT: (MANDATORY)

Assessment Time: _____ LOR _____ Pulse _____ SaO2 _____
RR _____ Breath Sounds _____ BP _____

PRECEPTOR SIGNATURE: _____

PRECEPTOR NAME/TITLE: _____

PRECEPTOR COMMENTS: _____

