**MEDICATION ADMINISTRATION CHART**

**Individual:** **HRT Provider:** **Month/Year**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Known Allergies: Pharmacy Name & Number:** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PCP Name & Number: Prescriber Name & Number: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Medication Information** | **Time** | **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:  Route:  Used for: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Medication Information** | **Time** | **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** |

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| Client Name (Print) |  | Client Signature |  | Client Initials |  |
| Provider Name (Print) |  | Provider Signature |  | Provider Initials |  |
| Other (Specify Role) |  | Signature |  | Initials |  |

**Individual:** **HRT Provider:** **Month/Year**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION ERRORS/REFUSALS**

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| In the event of a medication error:   * Call the doctor or pharmacy listed on the prescription bottle * Obtain the identifying information of the person instructing you * Write down any instructions you are given * Report the error to appropriate parties (state, HRT, parent/guardian) * Document on medication chart | In the event of a serious medication side effect:   * Call 911 immediately * Write down and follow instructions provided * If you are told to monitor, be sure you know what you are observing for * Notify parent/guardian, state, and HRT immediately following the above |

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| --- | --- | --- | --- | --- |
| Date | Type | Prescriber Recommendations | Time/Date HRT Notified | HRT Contact |
|  | Error  Refusal |  |  |  |
|  | Error  Refusal |  |  |  |
|  | Error  Refusal |  |  |  |
|  | Error  Refusal |  |  |  |
|  | Error  Refusal |  |  |  |

**MEDICATION CHANGES/CONCERNS/ALLERGIC REACTIONS**

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| Date | Concern, Allergic Reaction, Medication Changes, Follow Up Needed | Date/Person Reported To |
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**OVER THE COUNTER MEDICATION ADMINISTRATION**

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| Date | Time | Medication | Dose | Reason Administered | Results | Provider Signature |
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