Administered Medication Documentation

Client Name: ______________________________ Date: ______________

D.O.B. ____________________ Gender: ☐Male ☐Female

Notes: ____

____

MEDICATION ADMINISTERED: ____________________ Dosage: ______________

Frequency: ______________________________ Exp: ______________

Injection Site: ____

Lot #: ___________

Mental Status Exam: ____

____

Side Effects: ____

VITALS

Height: ____________________ Weight: ____________________

Pregnant: ☐Yes ☐No Last Monthly Period: ______________

Smoking Status: ______________ Heart Rate: ______________

Temperature: ______________ Respiratory Rate: ______________

Blood Pressure: ______________

Next Injection Date: ______________

____ ______________

11/2023

Signature/Credentials Date