DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

Medication Administration Record – Group Homes for Children

Use of form: Use of this form is voluntary. It may be used by Group Homes for children to verify compliance with DCF 57.25(3), (4) and (5). Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: Each entry shall be written in ink. Enter the name, dosage, times, contraindications and the start / end date for each prescribed, over-the-counter and supplement medication. Staff who administer medication sign and initial the back of the form for identification purposes. Each time medication is administered, staff shall initial the date and time. When the resident is on homepass or refuses the medication or there is any error in medication administration or adverse reaction, staff shall circle the date and time, enter the appropriate code and write a comment on the back of the form. The codes are **H**=Home pass; **R**=Refusal to take; **A**=Adverse reaction [comment must include steps taken to notify resident's healthcare provider, parent, guardian or legal custodian]; and **E**=Error in medication administration [comment must include steps taken to notify the resident's physician, and the department must be notified pursuant to DCF 57.13(1)(e)].

Name – Resident (Last, First, MI)	Birthdate (mm/dd/yyyy)	Month / Year (mm/yyyy)

Name – Physician	Telephone Number	Known Allergies – List

Start Date	End Date	Name of Medication / Strength / Dosage / Dosage Times / Contraindications	Time 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

SIGNATURE – Staff Person Administering Medication	Initials	**SIGNATURE** – Staff Person Administering Medication	Initials
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DATE	COMMENTS	INITIALS