MONADNOCK WORKSOURCE
CONTROLLED DRUG
MEDICATION LOG

MONTH/YEAR:_____

RESIDENTIAL:__xx_
DAY:____
COMBINED:____

DAILY INVENTORY		Date	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
PRN: Yes:_____		Amt.																															
No:_____		Initials																															
Prescriber:	Time	Amt. Used																															
		Amt. Left																															
Order Date:		Time Admin.																															
		Initials																															
Medication/Strength:	Time	Amt. Used																															
		Amt. Left																															
Dose:		Time Admin.																															
Route/Frequency:		Initials																															
	Time	Amt. Used																															
Purpose:		Amt. Left																															
		Time Admin.																															
Special Considerations:		Initials																															
	Time	Amt. Used																															
		Amt. Left																															
		Time Admin.																															
		Initials																															

Allergies:

Guardian:

Address:

Phone:

Nurse: Date:

Manager: Date:

Date	Time	Initials	Medication - Reason for Use/Omission - Other	Results Response - Instructions - Actions

		Initials	Staff Signature	Print Name