## Daily Observation Record of Self-Administered Medication

**Name of Resident:** _____

**Name of Physician:** _____
**Telephone Number:** _____
**Allergies:** _____
**Diagnosis:** _____
**Other Diagnosis:** _____

**Month of** _____ **200___**

| MEDICATION | DOSAGE | HOUR | 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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**X** - Held by Medical Order
**R** - Refused
**D/C** - Discontinued
**H** - Home Pass
**P** - Program or Day Care

Person supervising self-administered medication is to initial box under date and opposite hour taken

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