DEFY MEDICATION RECORD

DEFY SITE: _____

Name	Team	Drug Allergies	
Staff Responsible for Custody of Medication	Parent/Guardian Name	Parent/Guardian Phone #	

SCHEDULED MEDICATIONS

Medication (Name, Dose, Route, Frequency)	Date _ Hour _													

	Initials	Full Signature		Initials	Full Signature
1			4		
2			5		
3			6		

Name	Team	Drug Allergies	

PRN and ONE-TIME MEDICATIONS

MEDICATION (Dose, Route, Frequency)	Reason for Med	Date, Time, and Initials								Effects Noted

DOCUMENTATION of OMITTED DOSE of MEDICATION

MEDICATION (Dose, Route, Frequency)	Dose Omitted	Reason for Omission	Initials