

Human Resources Center, Inc.

Medication Log Self-Audit

Client Name-----	Yes _____	No _____
Month/Year -----	Yes _____	No _____
Allergies -----	Yes _____	No _____
Physician Name-----	Yes _____	No _____
Medication Name -----	Yes _____	No _____
Medication Dosage-----	Yes _____	No _____
Time Frequency-----	Yes _____	No _____
Date of Administration-----	Yes _____	No _____
Date Ordered-----	Yes _____	No _____
Refill Dates (if applicable) -----	Yes _____	No _____
Initialing Done by Staff		
Administering Medication-----	Yes _____	No _____
Initials Validated by Staff Member		
Administering Medication-----	Yes _____	No _____
Addendums completed (if applicable) -----	Yes _____	No _____

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Life Sharing Provider _____ Date: _____

Life Sharing Coordinator _____ Date: _____