Controlled Medication Count

Individual’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication/Strength:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quantity:\_\_\_\_\_\_\_\_

Medication Number (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_

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| Date | Time | Amount on Hand | Amount Administered | Quantity Remaining | Signature |
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