

# Medication Check-Off Form

Before medication packets can be distributed to clients, they need to be checked for accuracy. Please check the medication labels against the Medication Administration Record for accurate fill. Also note any recent med changes and verify accuracy. Please initial for each client as indicated below. If any errors are noted, please notify your supervisor and then take the medications for that time frame to the pharmacy for correction. Please keep this record in the medication section of the clients program book.

Client: \_\_\_\_\_ Program \_\_\_\_\_

Date	Correct Y/N	Staff Initials

Staff Signatures:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initials:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_