agency for persons with disabilities
State of Florida

CONTROLLED MEDICATION COUNT

Consumer _____

Medication_____

Dose_____

Month/Year_____

	1st shift			2nd Shift			3rd Shift		
DATE	On	Count	Off	On	Count	Off	On	Count	Off
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
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23									
24									
25									
26									
27									
28									
29									
30									
31									

Please sign and initial below to identify initials used in "on" and "off" columns above.

Signature	Initial	Signature	Initial	Signature	Initial