SENIORS AND PEOPLE WITH DISABILITIES
STATE-OPERATED COMMUNITY PROGRAM
MEDICATION COUNT SHEET
(For controlled/narcotic medications)

Client Name: _____ **Medication Name:** _____

Date of Physician's order: _____ **Dosage:** _____

Physician's Name: _____ **Method of Administration** _____

Rx Number: _____

DATE	TIME	AMOUNT ON HAND	AMOUNT RECEIVED	AMOUNT GIVEN	AMOUNT REMAINING	SIGNATURE	SIGNATURE