DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES

SHARED LIVING MONTHLY MEDICATION and TUBE FEEDING RECORD

INDIVIDUAL:_____ **DATE:**_____ **MCI#:**_____ **WEIGHT:**_____ **BLOOD PRESSURE:**_____ **(If applicable, please add weight and/or blood pressure.)**	Date of Refill	Number of Refills Left
1. Medication Prescribed_____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
2. Medication Prescribe_____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
3. Medication Prescribed _____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
4. Medication Prescribed _____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
5. Medication Prescribed_____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
6. Medication Prescribed _____ Directions: _____ Please record if medication not taken, reasons, and dates _____		

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INDIVIDUAL:_____ **DATE:** _____ **MCI#:**_____	Date of Refill	Number of Refills Left
7. Medication Prescribed _____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
8. Medication Prescribed _____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
9. Medication Prescribed _____ Directions: _____ _____ Please record if medication not taken, reasons, and dates _____		
10. Medication Prescribed _____ Directions: _____ Please record if medication not taken, reasons, and dates _____		
11. Tube Feeding Prescribed_____ Product Name: _____ Amount:_____ Feeding Schedule: _____ Amount of water given:_____		

All Listed Medications Taken as prescribed:_____

Signature of Person Assisting