PHARMACY ADMINISTRATION RECORD
PHYSICIAN ORDER FORM

PLACE COMPLETED FORM IN DRUG BOX TO BE RETURNED TO PHARMACY

DATE (mm/dd/yyyy)	INCIDENT #	OLD BOX #	RESEAL #
PATIENT'S NAME (Apply Patient Sticker if available)	PATIENT'S DOB (mm/dd/yyyy)	NEW BOX #	

MUST indicate whether STANDING (S) or ONLINE (O) Orders

MEDICATION	AMT ADMIN	S/O

MEDICATION	AMT ADMIN	S/O

NARCOTIC WASTED	AMOUNT	WITNESS SIGNATURE	RESEAL #

AIC NAME (printed)	AIC SIGNATURE
AIC CERT #	
EMS AGENCY NAME	

THIS PORTION COMPLETED ONLY if ONLINE ORDERS or NARCOTICS ADMINISTERED

PHYSICIAN NAME (printed)	DEA # (REQUIRED ONLY FOR NARCOTICS)	PHYSICIAN SIGNATURE

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