

IREDELL EMS CONTROLLED MED ADMINISTRATION / WASTE REPORT

DATE	TIME	UNIT# (IMED _) & ACR#	PATIENT NAME (1 ST Init/Last Name)	Morphine, Valium Versed, Ativan (Circle One)	Amt. Admin.	Amt. Wasted
				MS VAL VER ATI		
Administered By Sign:			Administered By Print:			
Wasted By Sign:			Wasted By Print:			
Witness Sign:			Witness Print:			

Notes or Comments: _____

Attach to Original Copy of ACR when fully completed.

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