Medication Administration Record (MAR)

Month/Year:

Medication Information		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Diagnosis:

DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.):

Comments:

Allergies:

Physician Name:

Phone Number:

A. **Put initials in appropriate box when medication is given.**
B. **Circle initials when not given.**
C. **State reason for refusal / omission on back of form.**
D. **PRN Medications: Reason given and results must be noted on back of form.**
E. **Legend: *S* = School; *H* = Home visit; *W* = Work; *P* = Program.**

NAME:

Signature/Initials:

Date of Birth:

Sex: