Medication Administration Record (MAR)

MO/YR: Start/Stop Date | Facility Name:

Medication		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
	Start																																
	Stop																																
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	Start																																
	Stop																																

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:	Record #	Date of Birth:	Sex:

VITAL SIGNS	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
TEMPERATURE																															
PULSE																															
RESPIRATION																															
WEIGHT																															

PRN AND MEDICATIONS NOT ADMINSTERED							Initials	Staff Signature
Date	Hour	Initials	Medication	Reason	Result			
						1		
						2		
						3		
						4		
						5		
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						18		
						19		

Name	MO/ YR