

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																																
	Start																																
	Stop																																
Diagnosis:		DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)														Comments																	
Allergies:					Physician Name										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.																		
					Phone Number																												
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	
						6	
						7	
						8	
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						11	
						12	
						13	
						14	
						15	
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						17	
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						19	
Name						MO/ YR	