Medication Administration Record (MAR)

*Individual Name: _____

Medication Name: _____

Month: _____ Year: _____

Dose Form: _____

*Program Name: _____

Medication Type: _____

Legend: ☐ Administered   ☐ Not Administered

Note: If the 'Record Type' differs from the above two you may fill in the boxes with the required initials from below:

M-Missed   **R**-Refused   **LOA** -Leave of Absence   **OH**-On Hold   **D**-Deleted

Drug Details:

Strength: _____   Give Amount/Quantity: _____   Measurement Unit: _____

Route: _____   Frequency: _____   Begin Date & Time: _____

End Date & Time:_____   Schedule Repeat: _____   Schedule Weekdays:_____

Schedule Time Slot(s):_____   Prescriber: _____

Day/Time	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

Indication/Purpose:_____

_____

Instruction/Comments:_____

_____

Administered By: _____Signature:_____Initials:_____ Date:_____Time:_____am/pm

Administered By: _____Signature:_____Initials:_____ Date:_____Time:_____am/pm

Administered By: _____Signature:_____Initials:_____ Date:_____Time:_____am/pm

Administered By: _____Signature:_____Initials:_____ Date:_____Time:_____am/pm

Administered By: _____Signature:_____Initials:_____ Date:_____Time:_____am/pm

SIGNATURE ………………………………… NAME ………………………………… DATE ………………………… TIME ……………………… am/pm

Note: Required fields are marked with an asterisk (*)