

## 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																												
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<b>Diagnosis:</b>		<b>DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)</b>										<b>Comments</b>																		
<b>Allergies:</b>		<b>Physician Name</b>										<b>A. Put initials in appropriate box when medication is given.</b> <b>B. Circle initials when not given.</b> <b>C. State reason for refusal / omission on back of form.</b> <b>D. PRN Medications: Reason given and results must be noted on back of form.</b> <b>E. Legend: S = School; H = Home visit; W = Work; P = Program.</b>																		
		<b>Phone Number</b>																												
<b>NAME:</b>										<b>Record #</b>										<b>Date of Birth:</b>					<b>Sex:</b>					

