MO/YR:		Name:	Date of Birth:	Sex:

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

Medication Administration Record (MAR)

DRUG: DOSE: FREQUENCY: SIDE EFFECTS: REASON FOR USE: SPECIAL INSTRUCTION(s): PHYSICIAN:	Start																																
	Stop																																
DRUG: DOSE: FREQUENCY: SIDE EFFECTS: REASON FOR USE: SPECIAL INSTRUCTION(s): PHYSICIAN:	Start																																
	Stop																																
DRUG: DOSE: FREQUENCY: SIDE EFFECTS: REASON FOR USE: SPECIAL INSTRUCTION(s): PHYSICIAN:	Start																																
	Stop																																

Allergies:	**DIET (Special Instructions):**	**STAFF SIGNATURE AND INITIALS:**
Pharmacy:	**Primary Care Physician:** **Primary Care Physician Contact 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. **If medication is taken another time, use D= Day program, R= Relative/ friend's home E= Elsewhere**

NAME OF FACILITY:	ADDRESS:	PHONE NUMBER:	

PRN AND MEDICATIONS NOT ADMINISTERED							Initials	Staff Signature
Date	Hour	Initials	Medication and Dosage	Reason	Result			
						1		
						2		
						3		
						4		
						5		
						6		
						7		
						8		
						9		
						10		
						11		
						12		
						13		
						15		

NOTES	STAFF INITIALS:	SIGNATURE:
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____