MEDICATION ADMINISTRATION RECORD (MAR)
(FOR MEDICATIONS GIVEN ROUTINELY OR FOR A LIMITED TIME)

CHILD'S NAME: _____ DOB: _____ ALLERGIES: _____

PARENT'S/GUARDIAN'S NAME: _____ DOCTOR: _____ TELEPHONE: _____

MONTH AND YEAR: _____

MEDICATION INFO	**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
MEDICATION NAME:																																
DOSAGE:																																
ROUTE:																																
REASON:																																
START DATE:																																
END DATE:																																
SPECIAL INSTRUCTIONS:																																

I, _____, the parent/guardian of the above listed child, give permission for the above medication to be administered.

_____ _____

Signature Date

DATE:	**TIME:**	**COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:**	**DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS**

NAME OF PERSON ADMINISTERING	**INITIALS**

ROUTE OF ADMINISTRATION; SELECT ONE

ORAL *(BY MOUTH)*
EYE DROPS *(OPTIC)*
NOSE DROPS/SPRAY *(NASAL)*
EAR DROPS *(OTIC)*
TOPICAL *(ON SKIN)*
INHALATION (*NEBULIZER)*
INJECTON (*SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE*)
RECTAL