# 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** |
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| **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 |