

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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Diagnosis:		DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)														Comments																		
Allergies:						Physician Name														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. Legend: <i>S</i> = School; <i>H</i> = Home visit; <i>W</i> = Work; <i>P</i> = Program.														
						Phone Number																												
NAME:									Record #											Date of Birth:						Sex:								