Medication Administration Record (MAR)

*Individual Name, ID: _____ Program Name: _____

Month: _____ Year: _____ MAR Form ID: _____

*Medication Name: _____ Medication Type: _____

Prescriber: _____

Begin Date & Time: _____ am/pm End Date & Time: _____ am/pm

Controlled Substance: _____ Drug Count Attached? ☐ Yes ☐ No

Drug Details:

Route: _____ Dose Form: _____ Strength: _____

Give Amount / Quantity: _____ Measurement Unit: _____ Frequency: _____

Schedule Time Slot(s): _____ Schedule Repeat: _____

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

Indication/Purpose: _____

_____

_____

_____

Instruction/Comments: _____

_____

_____

_____

For PRN Followups:

Administered Date & Time	Followup Date & Time	Followup By	Comments

SIGNATURE _____ **NAME** _____ **DATE** _____ **TIME** _____ am/pm

Note: Required fields are marked with an asterisk (*)