Medication Administration Record (MAR)

MO/YR:		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**
Initials/date-																																
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Diagnosis:	**DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)**		**Comments**

Allergies:	**Physician Name** **Phone Number**	**A. Put initials in appropriate box when medication is given.** **B. Circle 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.**

NAME:	**Record #**	**Date of Birth:**	**Sex:**

Initials	Signature	Initials	Signature	Initials	Signature

PRN AND MEDICATIONS NOT ADMINSTERED							Initials	Staff Signature
Date	Hour	Initials	Medication	Reason	Result	Hour		
Name							MO/ YR	