# 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 |
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| **MEDICATION NAME:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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** |
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**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