



Medication Administration Record (MAR)

agency for persons with disabilities Name: _____, Month: _____, Year: 20____

Allergies: _____

Medication	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		
Drug Name, Dosage, Route																																		
Prescribed By:																																		
Drug Name, Dosage, Route																																		
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Drug Name, Dosage, Route																																		
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Drug Name, Dosage, Route																																		
Prescribed By:																																		
NOTES:																																		

REASON MEDICATION NOT ADMINISTERED

- 1 = Home
- 2 = Work/ADT
- 3 = ER/Hospital
- 4 = Refused
- 5 = Medication not available – explain ⇨
- 6 = Held by MD – explain ⇨
- 7 = Other – explain ⇨

Time, date, and initial each explanation.

Sign and initial at the bottom of the form.

Name: _____

Record medication administration notes below. For medication not administered, use the codes in the box at the left, including appropriate dates, comments, and explanations.

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS