# 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 & YEAR:_____ MEDICATION NAME:_____

DOSAGE:_____ ROUTE:_____ REASON:_____

START DATE: _____ END DATE:_____

SPECIAL INSTRUCTIONS:_____

| Time | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
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| Time | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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I, _____, the parent/guardian of the above listed child, give permission for the above medication to be administered.

_____ _____

Signature Date

| Name of Person Administering | Initials |
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ROUTE OF ADMINISTRATION; SELECT ONE

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|---|---|
| ORAL (BY MOUTH) | EYE DROPS (OPTIC) |
| NOSE DROPS/SPRAY (NASAL) | TOPICAL (ON SKIN) |
| EAR DROPS (OTIC) | INHALATION (NEBULIZER) |
| INJECTION (SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE) | RECTAL |