Caring and serving since 1883®

Community Health and Counseling Services
Treatment Foster Care

Medical Administration Record (MAR)

Client Name: _____ Case #: _____ Month/Yr. _____

Date of Birth: _____ Allergies: _____

Physician's Name: _____ Physician's Telephone: _____

Physician's Name: _____ Physician's Telephone: _____

Medications	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

Title	Initials	Signature	Title	Initials	Signature

Instructions:

1. Initial appropriate day/time box when a medication is given.
2. Circle initials when a medication is refused.
3. When medication is missed, circle the box but do not initial (leave inside of the box blank)
4. List all allergies, medications, dosages and noted side effects.
5. For PRN medications, missed meds and refused meds, see reverse side for additional charting requirements.

Noted Side Effects: _____

Reviewed by: _____ Title: _____ Date: _____

Medication Administration Notes

Date	Time Given	Medication & Dosage	Reason	Results or Response	Time Noted	Initials

Instructions:

1. State reason for refusal of medication.
2. State reason for missed medication.
3. State reason and results/response for PRN medication.
4. Initial of adults passing medication to client.