

MEDICATION ADMINISTRATION RECORD (MAR)

MONTH/YEAR: _____

RESIDENT NAME
DATE OF BIRTH
ROOM / BED

ATTENDING PHYSICIAN
ALLERGIES
ID NUMBER

| Medication & Strength | Dosage | Route | Time | M | T | W | T | F | S | S | Notes |
|--------------------------------------|---------------|--------------|-------------|----------|----------|----------|----------|----------|----------|----------|--------------|
|--------------------------------------|---------------|--------------|-------------|----------|----------|----------|----------|----------|----------|----------|--------------|

NURSE/CARETAKER SIGNATURE

REVIEWING SUPERVISOR SIGNATURE / DATE

* Codes: A=Absent, R=Refused, H=Hospitalized, O=Other (See Progress Notes)