Medication Administration Record (MAR)

MO/YR:

Facility Name: Alay Home Care

Medication	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

Diagnosis:

DIET Special Instructions, e.g. texture, bite size, position, etc)

Comments:

Allergies

Physician Name

Phone Number

A. Put initials in appropriate box when medication is given.
B. Initial and Circle when not given
C. State reason for refusal/omission on back of form.
D. PRN Medications: Reason given, and results must be noted on back of form.

Name:

DDD ID #

DOB:

Sex:

Initials	Signature	Initials	Signature	Initials	Signature

PRN AND MEDICATIONS NOT ADMINSTERED					
Date	Hour	Initials	Medication	Reason	Result
Name					MO/YR