

# Medication Administration Record (MAR)

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Site: \_\_\_\_\_ School Year: \_\_\_\_\_

Teacher: \_\_\_\_\_ Name and Dosage of Medication: \_\_\_\_\_

Medical Concern: \_\_\_\_\_ Medical Expiration: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

	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
Aug.																															
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
March																															
April																															
May																															
June																															
July																															

**Directions: Initial with time of administration; a complete signature and initials of each person administrating medications should be included below.**

	INITIAL	SIGNATURE (of person administering medication)	DATE / COMMENTS
1.	_____	_____	_____ / _____
2.	_____	_____	_____ / _____
3.	_____	_____	_____ / _____
4.	_____	_____	_____ / _____