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.	_____	_____	_____/_____

White: Med bag/lock box Yellow: Nurse Revised 4/9/2021