

**MEDICATION ADMINISTRATION RECORD (MAR)**  
**(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)**

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_  
 PARENT'S/GUARDIAN'S NAME: \_\_\_\_\_ DOCTOR: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

MEDICATION INFO	TIME:	DATE:	NAME OF PERSON ADMINISTERING:	ROUTE OF ADMINISTRATION; SELECT ONE
<b>MEDICATION NAME:</b>				ORAL ( <i>BY MOUTH</i> ) EYE DROPS ( <i>OPTIC</i> ) NOSE DROPS/SPRAY ( <i>NASAL</i> ) EAR DROPS ( <i>OTIC</i> ) TOPICAL ( <i>ON SKIN</i> ) INHALATION ( <i>NEBULIZER</i> ) INJECTION ( <i>SYRINGE, PEN, OR ELECTRONIC INFUSION DEVICE</i> ) RECTAL
<b>DOSAGE:</b>				
<b>ROUTE:</b>				
<b>REASON:</b>				
<b>START DATE:</b>				
<b>SPECIAL INSTRUCTIONS:</b>				
<b><i>Dates and times of sunscreen, diaper cream, and insect repellent applications do not need to be documented. However, all other information and parent permission for these medications are required on the MAR.</i></b>				

I, \_\_\_\_\_, the parent/guardian of the above listed child, give permission for the above medication to be administered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

DATE:	TIME:	COMMENTS/MEDICATION ERRORS/ADVERSE EFFECTS:	DATE AND TIME PARENT/GUARDIAN INFORMED OF ERRORS OR ADVERSE EFFECTS