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

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**