Medication Administration Record (MAR)

Name: ________________________________ Month: ______________ Year:________

Medication/ dosage/ frequency/route	Time	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

Initial	Signature	Known allergies or adverse reactions:

PRN AND REFUSED MEDICATION NOTES

Date/Time	Medication/Dosage	Reason	Results	Hour/Initials

Vital signs or other tracking per physician or team request:

	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Weight						
Blood Pressure						
Temperature						
Pulse						
Other:						