agency for persons with disabilities
State of Florida

Medication Administration Record (MAR)

Name:______________________________________ Month:_______________, Year: 20___

Allergies: ____

Medication	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
Drug Name, Dosage, Route																																
Prescribed By:																																
Drug Name, Dosage, Route																																
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Prescribed By:																																

NOTES:	Signature	Initial	Signature	Initial

Name: ______________________________

Record medication administration notes below. For medication not administered, use the codes in the box at the left, including appropriate dates, comments, and explanations.

REASON MEDICATION NOT ADMINISTERED

1 = Home
2 = Work/ADT
3 = ER/Hospital
4 = Refused
5 = Medication not available – explain ⇨
6 = Held by MD – explain ⇨
7 = Other – explain ⇨

Time, date, and initial each explanation.

Sign and initial at the bottom of the form.

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS