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:																																
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NOTES:	**Signature**	**Initial**	**Signature**	**Initial**

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.

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.

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS