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|  | | **Medication Administration Record (MAR)**  Name: \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month:\_\_     \_\_\_, Year: 20  Allergies: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Drug Name, Dosage, Route |  | |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |
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Name:

Record medication administration notes below. Include date/time, name of medication, comments, and your initials. Sign below to identify your initials.

**COMMENTS – Reason medication not given, Reason PRN given, Response to PRN**

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