# 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** |
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