

**MEDICATION ADMINISTRATION RECORD (MAR)**  
**(FOR MEDICATIONS GIVEN AS NEEDED OR FOR EMERGENCY USE)**

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
 PARENT'S/GUARDIAN'S NAME: \_\_\_\_\_ DOCTOR: \_\_\_\_\_

MEDICATION INFO	TIME:	DATE:	NAME OF PERSON ADMINISTERING:	ROUTE OF ADMINISTRATION; SELECT ONE
MEDICATION NAME:				ORAL (BY MOUTH)
DOSAGE:				EYE DROPS (OPTIC)
ROUTE:				NOSE DROPS/SPRAY (NASAL)
REASON:				EAR DROPS (OTIC)
START DATE:				TOPICAL (ON SKIN)
SPECIAL INSTRUCTIONS:				INHALATION (NEBULIZER)
				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 and parent permission 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