# Medication Administration Record (MAR)

| **Individual Name:** (Required) | **D.O.B:** (Required) |
|---|---|
| **Diagnoses:** (Required) | **Diet:** (Required) |
| **Known Allergies:** (Required) | |
| **Month:** (Required) | **Year:** (Required) |

Medication: Dosage: Frequency: Route:

| 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 |
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Medication: Dosage: Frequency: Route:

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Medication: Dosage: Frequency: Route:

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PDP Direct Support Staff (Print Name) PDP Direct Support Staff (Signature) Date

PDP Direct Support Staff (Print Name) PDP Direct Support Staff (Signature) Date

PDP Direct Support Staff (Print Name) PDP Direct Support Staff (Signature) Date

Please use the following code if a medication was not administered by an employee
UPS – Unpaid Support H – Hospital N – Nurse S – School W – Work/Workshop Provider Number: #2502456