

Medication/Treatment Administration Record (MAR/TAR)

Name:		DOB:		Gender:																													
Diagnosis:		Diet:		Special dietary instructions (texture, bite size, positioning etc.):																													
Allergies:		Physician Name:		A. Put initials in appropriate box when medication is given B. Circle initials when not given C. State reason for declining/omission on back of form D. As Needed Medications: Reason given and results must be noted on back of form E. Legend: S = School; H = Home visit; W = Work; P = Program																													
		Phone Number:																															
Month/Year:		Facility/Agency/Provider Name:																															
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
		Purpose and Common Side Effects:																															
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[illegible]

As Needed Medications Administered and Routine Medications Not Administered						Initials		Personnel Signature					
Date	Hour	Initials	Medication	Reason	Result								
						1							
						2							
						3							
						4							
						5							
						6							
						7							
						8							
						9							
						10							
						11							
						12							
						13							
						14							
						15							
						16							
						17							
Name:						DOB:				Month/Year:			