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|  |  **Medication Administration Record (MAR)**Name: \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month:\_\_     \_\_\_, Year: 20     Allergies:       |
| **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 |
| Drug Name, Dosage, Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Drug Name, Dosage, Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Drug Name, Dosage, Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Drug Name, Dosage, Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Drug Name, Dosage, Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **NOTES:** | **Name (print)/Signature** | **Initial** | Name (print)/Signature | Initial |
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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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| DATE/TIME | MEDICATION | COMMENT | INITIAL |
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