agency for persons with disabilities
State of Florida

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																																
Prescribed By:																																
Drug Name, Dosage, Route																																
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Drug Name, Dosage, Route																																
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Drug Name, Dosage, Route																																
Prescribed By:																																

NOTES:	**Name (print)/Signature**	**Initial**	**Name (print)/Signature**	**Initial**

APD Form 65G-7.008 A, effective April 2019
Rule 65G-7.008, F.A.C.

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

DATE/TIME	MEDICATION	COMMENT	INITIAL

Name (print) / Signature	Initials	Name (print) / Signature	Initials	Name (print) / Signature	Initials