MEDICATION ADMINISTRATION RECORD (MAR)

NOTE: This form should be used for all non-psychotropic medication.

Child's Name:	Date of Birth:	Sex:
Facility Name & Number or Foster/Certified/Resource Family Agency Name:		MO/YR:

Prescription Details	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
Medication Name:																																
Required Dosage: Time & Frequency of Dose:																																
Quantity Prescribed: Prescription Filled Date:																																
Prescription #: # of Refills:																																
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Allergies:		Date and Description of Any Observed Side Effects:
Monthly Weight & Date:	Anticipated Refill Date:	
Pharmacy Name & Number:	Physician Name & Number:	A. Fill in what time the child takes the medication in the "TIME" column. B. Put initials in appropriate box when medication is given. C. Circle initials when not given. D. State reason for refusal / omission on page 2 of 2. E. PRN Medications: Reason given and results must be noted on page 2 of 2. F. *S* = School; *H* = Home visit; *W* = Work; *P* = Program; *R* = Refusal; *O* = Other
Additional Instructions From Physician:		
Placement Worker Name & Number:		

MEDICATIONS NOT ADMINISTERED						Initials	Staff Signature
Date	Hour	Medication Name	Reason	Result			
					1		
					2		
					3		
					4		
					5		
					6		
					7		
					8		
					9		
					10		
					11		
Name:						MO / YR:	

All Staff/Caregivers please sign and initial below in order to identify initials.					
Signature	Initials	Signature	Initials	Signature	Initials

INSTRUCTIONS FOR LIC 622A – MEDICATION ADMINISTRATION RECORD (MAR)

Record onto the MAR immediately after each medication is self-administered by the child. This is the only way to be sure that the right medication was taken, by the right person, at the right time, by the right route. Refer to the MAR Legend for additional instructions with this form.

CHILD'S NAME
- Enter the full name of the child that will be taking the medication.

DATE OF BIRTH
- Enter the child's date of birth.

SEX
- Enter the biological sex (at birth) of the child that is listed in their file.

FACILITY NAME & NUMBER OR FOSTER/CERTIFIED/RESOURCE FAMILY AGENCY NAME
- Enter the name of the Licensed Community Care facility or home in which the child resides.

MO/YR
- Enter the month and year that the information in this log was documented.

PRESCRIPTION DETAILS
- Information for this section can be found on the label of the child's medication.
- This section is required to be filled out pursuant to Health and Safety Code section 1507.6(b)(2)(B)(i)-(vi).

TIME
- In the "Time" column should be the hour that the medication is to be taken. The numbers in the top row of this table reflect the days of the month. The adult filling out this MAR shall initial each box that corresponds with the appropriate date and time a child self-administers their medication. If a medication is not taken as prescribed for any reason, follow the instructions in the MAR Legend. Notify the appropriate person(s) of the missed medication according to your facility's or agency's policies.

ALLERGIES
- If the child is allergic to food, medication, etc., enter that information here

DATE AND DESCRIPTION OF ANY OBSERVED SIDE EFFECTS
- It is a best practice to monitor and document the children's reactions to their medication. If the child reports that he/she is experiencing side effects from a medication or if staff observes side effects or changes in behavior, staff should document the reported or observed side effects in this section.

MONTHLY WEIGHT & DATE
- It is a best practice to monitor and document the child's weight on a monthly basis. Enter the child's weight in this section and the date that the weight was taken.

ANTICIPATED REFILL DATE
- Information for this section can be determined by monitoring the number in the Quantity Prescribed section and the date that the child first began taking the medication. The facility or agency should have a policy in place to ensure timely requests for refills.
- Enter the date in which this medication will need to be refilled

PHARMACY NAME & NUMBER
- Enter the pharmacy's name and phone number. (This can be found on the pharmacy label of the medication.)

PHYSICIAN NAME & NUMBER
- Enter the prescribing physician's name and phone number in this section.

ADDITIONAL INSTRUCTIONS FROM PHYSICIAN
- Refer to the child's prescription for this information.

PLACEMENT WORKER NAME & NUMBER
- Enter the placement worker's name and phone number in this section. (Refer the child's file for this information.

MEDICATIONS NOT ADMINISTERED

DATE
- Enter the date that the medication was not self-administered as directed by the prescription.

HOUR
- Enter the time that the medication was not self-administered as directed by the prescription.

MEDICATION NAME
- Enter the name of the medication that was not self-administered as directed by the prescription.

REASON
- Explain the reason the medication was not self-administered as directed by the prescription.

RESULT
- Note any observed or reported behaviors or symptoms that may have resulted from the child's missed medication, (For instance: child became hyperactive, child became aggressive, child complained of a headache, etc.)

INITIALS
- Enter the initials of the caregiver/staff member who was supervising the child when the medication was missed.

STAFF SIGNATURE
- The caregiver/staff member who was supervising the child when the medication was missed will need to sign here.