MEDICATION ADMINISTRATION RECORD

Child's Name:____ Date of Birth: __________________

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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NOTES:	**Signature**	**Initial**	**Signature**	**Initial**

AUTHORIZATION TO DISPENSE MEDICATION

I hereby authorize (*Name of Child Care Program)* to administer the following prescription and/or over-the-counter medication(s) to

______________________________, ___________________________.

Name of Child *Date of Birth*

Name of Medication:	Dosage:	Time(s) of Administration:	Prescribing physician (When applicable):

MEDICATION MUST BE IN ITS ORGINAL CONTAINER WITH THE CHILD'S NAME ON IT.

__________________________________ __________________________________ ____________________

Name of Parent or Guardian (Please print) Signature of Parent or Guardian Date

Updates and Changes: Medications added, discontinued, or dosages/times changed:

Medication/Dosage:	Change:	If an addition, time(s) of administration:	Signature of Parent or Guardian	Date

Instructions for completing Medication Administration Form:

- Anyone who is responsible for administering medication to this child must sign and initial the MAR.
- "Route" refers to how the medication in administered: orally, by injection, or topically.
- Any omissions from administering medications as prescribed should be noted by a circle instead of initials, and a corresponding note should be entered.
- Program closure days, such as weekends and holidays, should be indicated with an "X".