Medication/Treatment Administration Record (MAR/TAR)

Name:	DOB:	Gender:
Diagnosis:	Diet:	Special dietary instructions (texture, bite size, positioning etc.):
Allergies:	Physician Name: Phone Number:	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
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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Medication/Treatment Administration Record (MAR/TAR)

Vital Signs:	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
Temperature																															
Pulse																															
Respiration																															
Blood Pressure																															
Weight																															

As Needed Medications Administered and Routine Medications Not Administered					
Date	Hour	Initials	Medication	Reason	Result

	Initials	Personnel Signature
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		

Name: **DOB:**

Month/Year: