Family Respite Program
Medication Administration Record

Name of Child: _____ Age: _____ Gender: _____

Address: _____

Parent/Guardian:

Print: _____ Sign: _____ Date: ___/___/____

Medication/Dosage/Route/ Frequency/Prescriber Parent/Guardian: fill in medication as instructed.	Date(s)/Time(s) Administered Provider: write in date/time & initial.	For over-the-counter (OTC) medication: Follow-up in one (1) hour; helpful, not helpful

Provider:

Print: Sign: Date: ___/___/____

Medication administered from: _____ to _____ (period may not exceed than 30 days)

See Backside for Additional MAR

Medication/Dosage/Route/ Frequency/Prescriber Parent/Guardian: fill in medication as instructed.	Date(s)/Time(s) Administered Provider: write in date/time & initial.	For over-the-counter (OTC) medication: Follow-up in one (1) hour; helpful, not helpful