PRIMA HOME HEALTH, INC.
Medication Administration Record (MAR)

MO/YR:	Start/Stop Date		Facility Name:																														
Medication		**Hour**	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
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Diagnosis:	**DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)**	**Comments**
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 refusal / omission on back of form.** **D.** **PRN Medications: Reason given and results must be noted on back of form.** **E.** **Legend: *S* = School; *H* = Home visit; *W* = Work; *P* = Program.**

NAME:	**Record #**	**Date of Birth:**	**Sex:**

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																															
WEIGHT																															

PRN AND MEDICATIONS NOT ADMINSTERED							Initials	Staff Signature
Date	Hour	Initials	Medication	Reason	Result			
						1		
						2		
						3		
						4		
						5		
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Name						MO/ YR		