

Children's H♥PE

Making a Difference!

DOCUMENT EACH DOSE,
SUBMIT EVERY MONTH
MEDICATION IS GIVEN

Client: _____ DOB: _____ Placement Date: _____
 Resource Parent(s): _____ Month: _____ Year: _____

NON-PSYCHOTROPIC MEDICATION & HEALTH SUPPLEMENT ADMINISTRATION RECORD (MAR)

List all NON-psychotropic meds, over the counter meds (Ibuprofen, antacid, etc) and health supplements taken and why it was taken. Fill in record at time of each dose (do not pre-fill) using these definitions:

Initials=Given **Circled Initials**=Not given* **R**=Refused* **S**=Given at School **H**=Given at Home Visit **P**=Given at Day Program **O**= Other

Med/Supp:	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
Reason:																																
Med/Supp:	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
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Reason:																																

ASW Review: _____

Date and description of any observed side effects:	Additional instructions from physician, if any:
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*Document any missed or refused doses

Date	Hour	Reason	Who was notified?	Observed or reported behaviors or symptoms due to missed/refused dose

ASW initial and date here after final review: _____