RED MOUNTAIN
FAMILY SERVICES, INC.

Medication Administration Record (MAR)

Client Name ______________________________ DOB ______________ Month/Year ________

Allergies ____

Medication ______________________________ Generic Name ______________________

Mg. Of Tabs/Caps ______________________________ Frequency ______________ Exp. Date __________

Date Filled ______________________________ Doctor's Name ______________________

Reason for Medication ______________________________ Prescription # ______________________

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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____
TFC Parent Signature

____
TFP Initials

____
Respite Parent Signature

____
Respite Parent Initials

____
Bio Family Signature

____
Bio Family Initials

____
TC Initials Date

***Give Dates & reasons for missed dosages on the back of this form**
***Explain change in medication(s) on the back of this form**

Use this page for any explanations that are needed:

1.) What Medication did you dispose of? _____

_____

_____

When? _____

How? _____

2.) What changes occurred this month with regard to medications? _____

_____

_____

3.) Did you count the pills for each prescription when you picked them up? _____

_____

_____

4.) Errors?_____

_____

_____

Wrong amount of pills? _____

_____

Other-_____

_____

_____

Treatment Foster Parent Signature Date