Month: Year:

MEDICATION(S):	HOURS	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

ALLERGIES:

TREATMENTS:

Initial MEDS and identify initials below

INITIAL	SIGNATURE

Instructions:

1. List one medication per box on this form. Use trade name of drug & generic name if prescription label is different from Doctor's order.
2. Initial appropriate box on front of MAR when medications or treatments are given.
3. Circle initial and document on reverse side when medications or treatments are refused or withheld.
4. Circle initials and document on reverse side for all PRN medications.
5. Document disposed medications, including the number of PRNs
6. Treatments/Therapies/Dietary supplements should be also listed and initialed.

RESIDENT NAME:

OPERATOR's NAME:

DOCTOR'S NAME

PRN AND REFUSED MEDICATION RECORD

Date	Time	Initials	Medication	Reason given/refused	Outcome	Time observed

Vital Signs	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Weight										
Blood Pressure										
Heart Rate										