# **PDP Medication Administration Record (MAR)**

Individual Name:		Diagnoses:	
Physician:	D.O.B:		Diet:
Known Allergies:			
Month:		Year:	



#### **Medication:**

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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# **Medication:**

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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PDP Direct Support Staff (Print Name)

PDP Direct Support Staff (Signature)

Date

Please use the following code if a medication was not administered by an employee

NS – Natural Support

H – Hospital N – Nurse

S – School

W - Work/Workshop