

# Pediatric Inpatient Medication Administration Record (MAR)

Patient Name

MRN

DOB

Age

Allergies

Admit Date

Ward/Room

Primary Physician

## Medication Administration Record

| Medication Name | Dose | Route | Frequency | Scheduled Time | Date/Time Given | Given By (Initials) | Remarks |
|-----------------|------|-------|-----------|----------------|-----------------|---------------------|---------|
|                 |      |       |           |                |                 |                     |         |
|                 |      |       |           |                |                 |                     |         |
|                 |      |       |           |                |                 |                     |         |
|                 |      |       |           |                |                 |                     |         |
|                 |      |       |           |                |                 |                     |         |

Additional Notes

Reviewed By

Date

Signature