# Medication Administration Record – MAR
# For Weeklong Respite Campers
# August 9-14, 2026

Participant Name:_____

Person Completing Mar:_____

Relationship to Participant:_____

Signature of Person Completing this Mar:_____ Date:_____

Please complete this chart including all medications & supplements (both prescribed & over-the-counter) that the participant will be taking throughout the weekend/session. Please be sure the chart reflects the directions on the medication bottles. Medications will only be dispensed according to the directions on the bottle. Please remember:

- All medications must arrive in original bottles
- All instructions must be readable and prescription must be current, not expired
- All medications must be turned in to the nurse upon arrival at camp

Special Instructions or Comments:

_____

_____

Please bring a completed MAR to each session participant attends. Use additional sheets as needed.

| Name of Medication | Dose | What is it Used for? | Time | Sunday 8/9/2025 | Monday 8/10/2025 | Tuesday 8/11/2025 | Wednesday 8/12/2025 | Thursday 8/13/2025 | Friday 8/14/2025 | Nurse Initials |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | A.M. | | | | | | | |
| | | | Noon | | | | | | | |
| | | | P.M. | | | | | | | |
| | | | Bedtime | | | | | | | |
| | | | As Needed | | | | | | | |
| | | | A.M. | | | | | | | |
| | | | Noon | | | | | | | |
| | | | P.M. | | | | | | | |
| | | | Bedtime | | | | | | | |
| | | | As Needed | | | | | | | |
| | | | A.M. | | | | | | | |
| | | | Noon | | | | | | | |
| | | | P.M. | | | | | | | |
| | | | Bedtime | | | | | | | |
| | | | As Needed | | | | | | | |

Participant's Name:_____

| Name of Medication | Dose | What is it Used for? | Time | Sunday 8/10/2025 | Monday 8/11/2025 | Tuesday 8/12/2025 | Wednesday 8/13/2025 | Thursday 8/14/2025 | Friday 8/15/2025 | Nurse Inital |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | **A.M.** | | | | | | | |
| | | | **Noon** | | | | | | | |
| | | | **P.M.** | | | | | | | |
| | | | **Bedtime** | | | | | | | |
| | | | **As Needed** | | | | | | | |
| | | | **A.M.** | | | | | | | |
| | | | **Noon** | | | | | | | |
| | | | **P.M.** | | | | | | | |
| | | | **Bedtime** | | | | | | | |
| | | | **As Needed** | | | | | | | |
| | | | **A.M.** | | | | | | | |
| | | | **Noon** | | | | | | | |
| | | | **P.M.** | | | | | | | |
| | | | **Bedtime** | | | | | | | |
| | | | **As Needed** | | | | | | | |
| **Nurses:** Please add up doses for each day and grand total for the session | | | **Total Daily Doses** | | | | | | | **Grand Total** |

Nurse Name:_____ Nurse Signature: _____ Date:_____