Medical Administration Record

Participant Name: ____

Person completing MAR: ____

Relationship to participant: ____

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

- All medications must arrive in the original bottles.
- All instructions must be readable and the prescription must be current.
- All medications must be turned in to the nurse upon arrival at the camp.

Name of Medication	Dose	What is it used for?	Time	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
			A.M.							
			Noon							
			P.M.							
			Bedtime							
			As needed							
			A.M.							
			Noon							
			P.M.							
			Bedtime							
			As needed							
			A.M.							
			Noon							
			P.M.							
			Bedtime							
			As needed							
			A.M.							
			Noon							
			P.M.							
			Bedtime							
			As needed							
			A.M.							
			Noon							
			P.M.							
			Bedtime							
			As needed							

PLEASE USE ADDITIONAL SHEETS AS NEEDED

Special Instructions or Comments:

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Signature of Person Completing this MAR: ______________________________ Date Completed: ______________