Children's HOPE Foster Family Agency

"Making a difference, one child at a time!"

Client: ___ _______ DOB: _______________ Placement Date: __________

Resource Parent(s): ___ ____________________ ________ Month: _________ ___ Year: _________ __

NON-PSYCHOTROPIC MEDICATION & HEALTH SUPPLEMENT ADMINISTRATION RECORD (MAR)

List all NON-psychotropic meds, over the counter meds (Ibuprofen, antacid, etc) and health supplements taken and why it was taken. Fill in record at time of each dose (do not pre-fill) using these definitions:

Initials=Given **Circled Initials**=Not given* **R**=Refused* **S**=Given at School **H**=Given at Home Visit **P**=Given at Day Program **O**= Other

Med/Supp:	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
Reason:																																
Med/Supp:	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
Reason:																																
Med/Supp:	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
Reason:																																

Date and description of any observed side effects:	Additional instructions from physician, if any:

*Document any missed or refused doses

Date	Hour	Reason	Who was notified?	Observed or reported behaviors or symptoms due to missed/refused dose