

Washington, D.C. May 21-23, 2025

Medication Administration Record (MAR) **ONE medication per form**

Student Name							DOB	
School Known Allergies				Year			L	
					Height		Weight	
rescriber Infor	mation							
Name of Medication ONE PER FORM				Reason	for Use			
Posage Route				Frequer	Frequency			
Special Instructions		<u>l</u>						
Prescriber Signature				-		Phone		
Prescriber Name (print)				Date		Fax	Fax	
	n Authorization							
original container arent/Guardian Signatur	and be properly label	ed with the stud	Date	me of m		age, and st	rength.	#2 Contact Phone
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