Controlled Medication Administration Record (MAR)

Training Provider:_____

Staff Name:_____
(*a member of staff must be present when medication is taken by the student*)

Student Name :_____
Medication Name:_____

Dosage:_____

Directions given by parent/carer:
_____

Date	*Time*	*Amount Administered (by learner)*	*Amount remaining on site (in secure area)*	*Signature of Student*	*Verification Signature*		
					Date:	*Time:*	*am/pm*
					Date:	*Time:*	*am/pm*
					Date:	*Time:*	*am/pm*
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