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 : | |
| Dosage: | - |
| Directions given by parent/carer: | |

| Date | Time | Amount Administered (by learner) | Amount remaining on site (in secure area) | Signature of Student | Verification Signature | | |
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