

REQUIRED FOR ALL: Parent/Guardian Signature Delegating and Authorizing Administration:	Date:
COMPLETION OF MEDICATION: Parent/Guardian Sign indicating remaining medication returned to parent:	Date:

**LUTHERAN SOCIAL SERVICES CHILDCARE AND EDUCATION
MEDICATION or TUBE FEEDING ADMINISTRATION RECORD (MAR)**

Child's Name:	Dates Medication is to be Given (1 month max):
---------------	--

Name of Medication:

Dosage (amount to be given):	Time(s) to be Given:
------------------------------	----------------------

Side effects parents would like staff to watch for:

Medication is to be given (circle)with / in food? (Note type of food if applicable)

If medication must be crushed, or prepared in any other way, please describe:

Tips for Successful Administration, comfort of youth or other continued instructions:

<p>Instructions section ONLY required if Tube Feeding, Epi-pen, insulin (self admin by older student) or Nebulizer to include positioning of youth, method, etc:</p> <p>I, authorize the following staff to give my child the medication listed above using the instructions I have provided above. </p> <p>(parent name)</p> <p>I trained (staff names):</p> <p align="right">on / / at : am/pm</p> <p align="center">MEDICATIONS IN THIS CATEGORY WILL BE ADMINISTERED ONLY BY TRAINED STAFF LISTED ABOVE.</p>
--

MEDICATIONS MUST BE IN ORIGINAL CONTAINER. Dosage must match container.

DATE	TIME GIVEN		Staff Signature	Dbl Check Initials	Pill Count
	am	pm			
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

A second staff person will double check and initial before administration. For Controlled Medications, count pills remaining in the bottle.

DATE	TIME GIVEN		Staff Signature	Dbl Check Initials	Pill Count
	am	pm			
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					

Dropped Pill Log/ Medication Issue Log

Date	Time	Description of Issue	Staff Signature