

Medication Administration Record (MAR)

General Medication Form

(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name			Date of birth
Student address			
School	Grade/Class	Teacher	School year
List any known drug allergies/reactions		Height	Weight

Prescriber Authorization

Name of medication		Circumstance for use	
Dosage		Route	Time/Interval
Date to begin medication		Date to end medication	
Circumstances for use			
Special instructions			
Treatment in the event of an adverse reaction			
Epinephrine Autoinjector <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.			
Asthma Inhaler <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.			
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief			
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) To the student for whom it is prescribed (that should be reported to the prescriber) _____			
b) To a student for whom it is not prescribed who receives a dose _____			
Other medication instructions Does medication require refrigeration? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescriber signature		Date	Phone Fax
Prescriber name (print)			
Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.			

Parent/Guardian Authorization

<input checked="" type="checkbox"/> I authorize an employee of the school board to administer the above medication. <input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.			
<input checked="" type="checkbox"/> Medication form must be received by the principal, his/her designee, and/or the school nurse. <input checked="" type="checkbox"/> I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent's Statement:

In consideration for the overseeing and dispensing of medication for the above child, I hereby release and discharge the Toledo Catholic/ Private Schools, the Principal of the responsible school, his/ her designees, the nurse and any other persons connected with the overseeing and dispensing of medication or drugs herein described, from all claims, demands, actions, judgments and executions which may arise from the dispensing of medications. We (I) agree to notify the school personnel immediately if there is any change in either the treatment regimen or the authorizing physician. The undersigned have read this form and understand all of the terms.

Parent Signature

Date