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		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		Not applicable		Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector and have provided the student with training in the proper use of the autoinjector.			
Asthma Inhaler		Not applicable		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 3317.718 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 the medication require refrigeration?		YES		NO			
Is the medication a controlled substance?		YES		NO			
Prescriber signature		Date					
Prescriber name (print)							
Reminder note for prescriber: ORC 3317.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.							

Parent/Guardian Authorization

☐ I authorize an employee of the school board to administer the above medication ☐ I understand that additional parent/prescriber signed statements will be necessary if the dosage of the medication is changed. ☐ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☐ Medication form must be received by the principal, his/her designee, and/or the school nurse ☐ 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.

Parent/Guardian signature		Date	
#1 Contact phone		#2 Contact phone	

Parent/Guardian Self-Carry Authorization

	Medication is administered I will provide a backup dose of the medication to the school principal or nurse as required by law.
	For Asthma inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian signature		Date	
#1 contact phone		#2 Contact	