ADMINISTERING MEDICINES TO STUDENTS **File:** JHCD-E

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

Medicine Information

Name of Medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	

PRESCRIBER INFORMATION / AUTHORIZATION

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 on the proper use of the autoinjector

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 ORC3317.716 and 3317.718 to the student for whom it is prescribed (that should be reported to the prescriber)

Other medication instructions

Does medication require refrigeration? □ Yes □ No Is the medication a controlled substance? □ Yes □ No

Prescriber's Signature:	Date:	Phone:	Fax:

Prescriber's Name (Print)

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and a 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 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 must 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.

Parent/Guardian Signature	Date	#1 Contact Phone	# 2 Contact Phone

PARENT/GUARDIAN SELF-CARRY AUTHORIZATION

☐ For Epinephrine Autoinjector: As parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school 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 Phone

PARENT WAIVER OF LIABILITY STATEMENT

FOR PRESCRIBED AND NON-PRESCRIBED MEDICATION – PARENT(S) STATEMENT

Brief Description of Student's Condition: _____

How is medication/procedure to be administered? _____

Times medication should be administered: _____ Dosage: _____

I/We request authorized school personnel to administer the above medication/procedure to my child, as prescribed by the physician or myself, under the following conditions: 1) I/We will assume responsibility for the safe delivery of the medication to school; 2) I/We will notify the school immediately if there is any change in the use of the medication or the prescribed treatment, and 3) I/We release and agree to hold the Bloom-Carroll Board of Education, the Bloom-Carroll Local School District, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent(s) Date

_____ _____ _____
Home Telephone Work Telephone Cell Telephone(s)

[Adoption date: Pending]