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			

Prescriber Authorization

Name of Medication		Circumstance for Use
Dosage	Route	Time/Interval
Date to Begin		Date to End (if no date indication, authorization will be void at end of school year)

Special Instructions

Possible Severe Adverse Reaction(s)

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 appropriately 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 3313.716, 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 expectant relief

Possible Severe Adverse Reaction(s) per ORC 3313.716 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

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

- ☐ I authorize an employee of the school district 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 orders.
- ☐ Medication form must be received by the principal, his/her designee, and/or school health provider.
- ☐ I understand that the medication must be in the original container and be properly labeled with the students name, prescriber'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.
- ☐ I will assume responsibility for safe delivery of the medication/drug to the school. The medication must be delivered by an adult.
- ☐ I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

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

Parent/Guardian Self Carry Authorization

- ☐ ***For Epinephrine Autoinjector***: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, as the school and an 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 principal or school health provider 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