

Central College Christian School
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		Circumstances for Use		
Dosage	Route	Time/Interval		
Date to begin Medication		Date to End Medication		
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 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 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 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 (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 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 a member of the school office staff to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
 Medication form must be received by the Office Staff. 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 of the drug expiration when appropriate.

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, 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 principal or office staff 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
---------------------------	------	------------------	------------------