

# OUR SHEPHERD LUTHERAN SCHOOL

508 Mentor Avenue, Painesville, OH 44077

# MEDICATION ADMINISTRATION RECORD (MAR)

Fax: 440-358-1149

School Number: 440-357-7776

## STUDENT INFORMATION

STUDENT NAME			DATE OF BIRTH
ADDRESS			
SCHOOL	GRADE	TEACHER	SCHOOL YEAR
LIST ANY KNOWN DRUG ALLERGIES/REACTIONS			

## 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 ADVERSE REACTION			
<b>EPINEPHRINE AUTOINJECTOR</b> <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.			
<b>ASTHMA INHALER</b> <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 3313.718 A. TO THE STUDENT FOR WHOM IT IS PRESCRIBED (THAT SHOULD BE REPORTED TO THE PRESCRIBER)			
POSSIBLE SEVERE ADVERSE REACTION(S) PER ORC 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/GUARDIAN SELF-CARRY AUTHORIZATION

<input type="checkbox"/> 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 nurse as required by law.			
<input type="checkbox"/> 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

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