Euclid City Schools
Medication Administration Record (MAR)
General Medication Form
(Including Asthma Inhaler and Epinephrine Auto injector Use)

Student Information

Student name			Date of birth
Student address			
School	Grade	Teacher	School year
List all known drug allergies/reactions			

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	Medication Expiration Date
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 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/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 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 who receives a dose

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 back-up ephinephrine auto injector and best practice recommends back-up asthma inhaler

Parent/Guardian Authorization

- ☐ I authorize an employee of the school district to administer the above medication.
- ☐ I understand that additional parent/prescriber statements will be necessary if the dosage of medication is changed.
- ☐ I authorize the licensed healthcare professional to speak with the prescriber or pharmacy to clarify medication order.
- ☐ Medication form must be received by the school's health monitor/district 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, strength, time interval, route of administration and the date of drug expiration when appropriate.

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