WEST GEAUGA LOCAL SCHOOL DISTRICT

8615 Cedar Road, Chesterland, OH 44026

MEDICATION ADMINISTRATION RECORD (MAR)

General Medication Form

(including Asthma Inhaler and Epinephrine Autoinjector Use)

Fax: High School 440-729-5959 / **Middle School** 440-729-5909 / **Lindsey** 440-729-5989 / **Westwood** 440-729-5924

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		

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 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? ☐ **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 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 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

☐ *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.*

☐ *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**

☐ File per district policy

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MEDICATION DROP-OFF / PICK-UP INSTRUCTIONS
for Parent/Guardian

DEAR PARENT OF: _____
STUDENT NAME

IF YOUR CHILD MUST TAKE MEDICATION DURING THE SCHOOL YEAR, HE/SHE MUST HAVE THE FOLLOWING:

PART 1: DROP-OFF AND PICK-UP INSTRUCTIONS FOR PARENTS

Medication drop-off instructions

Parent/guardian must drop off medication (or designate a responsible adult) to deliver the medication to school designated location.

The Ohio Revised Code and school district policy state you must have:

- ☐ Written medication authorization record from your child's licensed health care prescriber and signed permission from the parent/guardian (school will provide necessary forms).
- ☐ Pharmacy-labeled original bottle or original container with student name and grade of non-prescription.

Other Comments:

Medication pick-up instructions

If your child's medication is discontinued **during** or **after the end of the school year**, safe arrangements must be made for the safe return. Please indicate your choice of how you prefer us to handle the return of your child's medication once discontinued by the health care prescriber or at the end of the school year.

- ☐ I will come into the school office/clinic when my child's medication is discontinued by the health care prescriber or it is the end of the school year.
- ☐ I request that the school dispose of any medication remaining after the last day of school. (If this form is not returned, medication will be properly discarded _____ week(s) after school ends.)

I give the school permission to send my child's:

- ☐ Epinephrine autoinjector or
- ☐ Asthma inhaler home with my child on this date _____. I assume all responsibility for the medication after it leaves the school.

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

PART 2: FOR SCHOOL NURSE/PERSONNEL ONLY

Your child, _____ has _____ of _____ left in the clinic.
amount left medication name

Please follow all medication instructions above to ensure safe medication practice.

School nurse/School personnel signature	Title	Phone	Date

Please contact the school for any questions or concerns

☐ File per district policy