

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		Height	Weight

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 an adverse reaction			
Epinephrine Autoinjector	<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.		
Asthma Inhaler	<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 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			
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

Medication Documentation Record (MDR)

Student name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home address		Student ID#	Photo
Grade/Class	Date of birth	Teacher	School		
Parent/Guardian name	Parent/Guardian emergency contact numbers (include all)				

Best Safe Practice: (Triple check) right student, right medication, right dose, right time, right route (compare with Medication Administration Order/MAR)
 Medication in original container/prescription bottle

Medication name:	Begin date:	End date (if known):	Discontinued order date:
Medication dosage:	Possible adverse reactions:		
Medication time:	Special instructions:		

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
August																																
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Medication Count

Nurse/staff signature	Initials	Medication name	Arrival date	Initial count	Wasted amount and date	Parent notified Yes or No	Count sent home and date

X = No school
 AB = Absent
 ER = Error
 O = No medication available
 F = Field trip
 H = Hold

Notes: _____

Medication Incident Report

Student Information

Student name		Student ID
Date of birth	Age	Weight
School	Grade/Class	Teacher

Incident

Date of Incident	Time of Incident	Reported by (name and title)
Type of Incident (<input checked="" type="checkbox"/> Check if applicable)		
<input type="checkbox"/> Unable to locate student <input type="checkbox"/> Student refused medication <input type="checkbox"/> Incorrect student <input type="checkbox"/> Incorrect time <input type="checkbox"/> Incorrect dose	<input type="checkbox"/> Incorrect route <input type="checkbox"/> Incorrect transcription <input type="checkbox"/> Incorrect technique <input type="checkbox"/> Medication wasted <input type="checkbox"/> Medication not available	<input type="checkbox"/> Medication outdated <input type="checkbox"/> Medication bottle mislabeled <input type="checkbox"/> Omitted dose(s) <input type="checkbox"/> Possible adverse reaction <input type="checkbox"/> Other _____
Description of incident above		

Contacted

<input checked="" type="checkbox"/> Check if applicable	Time	By Whom
<input type="checkbox"/> Healthcare provider		
<input type="checkbox"/> School nurse or RN		
<input type="checkbox"/> Parent/guardian		
<input type="checkbox"/> School administrator		
<input type="checkbox"/> Unable to contact parent/guardian		
<input type="checkbox"/> 911		
<input type="checkbox"/> Poison Control (800-222-1222)		

Student Outcome (Check if applicable)

<input type="checkbox"/> Return to class <input type="checkbox"/> Refer to physician's office <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> 911 called <input type="checkbox"/> Other _____	<input type="checkbox"/> Sent home with parent/guardian <input type="checkbox"/> Refer to Urgent Care <input type="checkbox"/> Refer to Emergency Department <input type="checkbox"/> School days missed _____
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Signature

Form completed by	Title	Date
School nurse	Title	Date
School administrator/principal	Title	Date