Morgan Local School District, 65 Union Ave., McConnelsville, OH 43756 PH 740-962-2782
Fax: High School--740-962-6005 / Morgan Junior High--740-962-3389
East Elementary--740-962-6804 / South Elementary--740-559-2864 / West Elementary--740-342-7326

Medication Administration Record (MAR)
Prescription Medication Form
(Including Asthma Inhaler & Epinephrine Autoinjector Use)

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	
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 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)

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 date of drug expiration when appropriate.

Parent /Guardian signature _____ ***Date*** _____

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*** _____