Print Form

Reset Form

FIRELANDS LOCAL SCHOOL DISTRICT

112 N. Lake St., South Amherst, OH 44001

PRESCRIPTION MEDICATION ADMINISTRATION RECORD (MAR)

(including Asthma Inhaler and Epinephrine Autoinjector Use)

FAX: ☐ **High School (gr 9-12) 440-965-5296** Phone: 440-965-4255 ☐ **Middle School (gr 6-8) 440-986-7022** Phone: 440-986-7021 ☐ **Elementary (gr K-5) 440-965-8849** Phone: 440-965-5381

STUDENT INFORMATION

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

PRESCRIBER AUTHORIZATION

NAME OF MEDICATION		
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** ☐ **NO, MAY NOT SELF-CARRY**

☐ **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** ☐ **NO, MAY NOT SELF-CARRY**

☐ **Yes, if conditions are satisfied per ORC 3313.716, 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 the school nurse or other trained 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 school nurse 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**

FIRELANDS LOCAL SCHOOL DISTRICT
112 N. Lake St., South Amherst, OH 44001
Fax: High School (gr 9-12) – 440-965-5296/ **Middle School (gr 6-8)** –440-986-7022 / **Elementary (gr K-5**) – 440-965-8849

MEDICATION DROP-OFF / PICK-UP INSTRUCTIONS

PARENT/GUARDIAN OF: _____
STUDENT NAME

MEDICATION DROP OFF:

IN ORDER FOR MY CHILD TO RECEIVE MEDICATION AT SCHOOL, I UNDERSTAND THAT ONLY I OR ANOTHER RESPONSIBLE ADULT MAY BRING MEDICATION INTO THE SCHOOL.

According to Ohio Revised Code and school district policy, I must also provide:

√ Written medication authorization record from my child's licensed health care prescriber, signed by both prescriber and parent/guardian (front side of this form).

√ Pharmacy-labeled original bottle or original container with student name and grade.

MEDICATION PICK-UP INSTRUCTIONS:

ARRANGEMENTS MUST BE MADE FOR THE SAFE RETURN OF LEFT OVER MEDICATION. I UNDERSTAND THAT NO MEDICATION IS EVER SENT HOME WITH A STUDENT, EXCEPT IN THE TWO CASES BELOW:

☐ 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. If I do not pick up the medication, I understand it will be properly discarded on the second day after school ends.

☐ I request that the school dispose of any medication remaining after the last day of school.

For epinephrine autoinjector or asthma inhaler only:

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

☐ Epinephrine autoinjector with my child on this date _____ or last day of school. I assume all responsibility for the medication after it leaves the school.

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

NO OTHER MEDICATIONS WILL BE SENT HOME WITH A STUDENT.

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

Please contact the school for any questions or concerns