BUCKEYE VALLEY LOCAL SCHOOL DISTRICT

PF2-7/11

Medication Administration Record (MAR)
General Medication Form
(In accordance with ORC 3313.713)

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	
Special instructions			
Treatment in the event of an adverse reaction			
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief			
Other medication instructions Does medication require refrigeration? □Yes □No		**Is the medication a controlled substance? □Yes □No**	
Prescriber signature (needed for prescription medications only)	Date	Phone	Fax
Prescriber name (print)			

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. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. 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

Revised 4/15