OLD FORT LOCAL SCHOOL DISTRICT
Home of the Stockaders

Parental/Guardian Notification

If your child will be taking medication (either prescription and/or non-prescription) during the school year, please complete the following forms. Since we do not have a full time school nurse on staff, the medication will be securely stored in the high school office. *VERBAL PERMISSION FROM THE PARENT WILL NOT BE ACCEPTABLE AT ANY TIME!*

The Ohio Revised Code and the School District Policy do not permit the administration of prescription medication until receipt of the "Authorization for Administration Form" (ALL 3 pages) is complete and signed by the parent **AND** the physician.

If your child takes a non-prescribed medication, there is also a form attached for that and must be signed by the parent BEFORE medication can be stored or given to your child at school.

Please remember that all medication must be in a pharmacy labeled bottle or the original container for non-prescription medication.

Please feel free to contact the high school office if you should have any questions regarding this.

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
- ❑ 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 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? ❑ 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