Dear Doctor,
The parent has reported that this child has an allergy that may be severe. Please complete the following forms, so we can make appropriate arrangements for care.
Student's Name:_____D.O.B:_____
ALLERGY TO:_____
Asthmatic Yes* No *Higher risk for severe reaction
TREATMENT ..

Symptoms:	**Give Circled Medication**
If contact with possible allergen, but no symptoms:	Epinephrine .. Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine .. Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	Epinephrine .. Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine .. Antihistamine
Throat† Tightening of throat, hoarseness, hacking cough	Epinephrine .. Antihistamine
Lung† Shortness of breath, repetitive coughing, wheezing	Epinephrine .. Antihistamine
Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine .. Antihistamine
Other† _____	Epinephrine .. Antihistamine
If reaction is progressing (several of the above areas affected), give:	Epinephrine .. Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.
DOSAGE
Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg Auvi-Q

Antihistamine:
give_____
medication/dose/route
Other:
give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

_____ _____
***PHYSICIAN'S SIGNATURE* Date

_____
PARENT/GUARDIAN SIGNATURE
Physician's signature required for allergy requiring medication

Barberton City Schools
Medication Administration Record (MAR)
(Including Asthma Inhaler and Epinephrine Autoinjector Use)
Student Information

Student Name				Date of Birth
Student Address				
School	Grade	Teacher		School Year
List my 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:	☐ Epipen in locked cabinet in office ☐ 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:	☐ Inhaler in locked cabinet in office ☐ Self Carry, Yes, if conditions are satisfied per ORC 3317716, 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 if it does not produce the expected relief			
Possible Severe Adverse Reaction(s) per ORC 3317716 and 3313718 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 received 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 3313718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler			

Parent/Guardian Authorization

☐ I authorize an employee of the 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
Principal signature			Date