

**Barberton City Schools  
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	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:	<input type="checkbox"/> Epipen in locked cabinet in office <input type="checkbox"/> 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:	<input type="checkbox"/> Inhaler in locked cabinet in office <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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**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