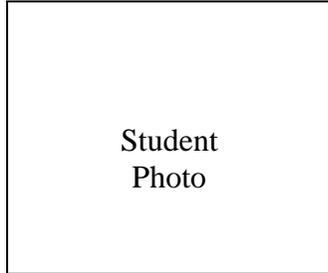




**ADMINISTRATION OF MEDICATION  
AT SCHOOL**  
(Medication Administration Record – MAR)  
\*\*\*\*\* One Medication per Form \*\*\*\*\*



Student  
Photo

School \_\_\_\_\_ Grade \_\_\_\_\_

Student \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Name of Medication and Dosage \_\_\_\_\_

Times of Day to be administered \_\_\_\_\_

Number of Times/Intervals Medication is to be administered \_\_\_\_\_

Side effects of medication \_\_\_\_\_

Date to Begin Medication \_\_\_\_\_ Date to End Medication \_\_\_\_\_

Adverse/Severe Reaction that Should be Reported to Physician \_\_\_\_\_

Special Instructions for Administration of Medication \_\_\_\_\_

This medication can be safely administered by non-medical personnel  Yes  No

This medication can be self-administered in the presence of a staff member  Yes  No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours  Yes  No

This emergency medication can be kept in the student's possession (Only applicable for epi pen, inhaler, seizure medication)  Yes  No  N/A

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

\_\_\_\_\_  
Prescriber's Printed Name Tel \_\_\_\_\_

\_\_\_\_\_  
Prescriber's Address

\_\_\_\_\_  
Prescriber's Signature Date \_\_\_\_\_

Please regard my signature below as my assurance that I release \_\_\_\_\_ School, psi, and any or all of the school's and psi's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I authorize direct contact with the prescriber if there is an emergency reaction situation. I further authorize school personnel to administer medication. I authorize my child to take the over the counter medication listed above at school in the presence of an authorized staff member. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

\_\_\_\_\_  
Parent's Printed Name Tel \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature Date \_\_\_\_\_