PRESCRIBER AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

***** One Medication per Form *****

Student Photo

School _____

Student _____ Grade/Rm_____

Address _____

City/State/Zip _____

Name of Medication and Dosage _____.

Times of Day to be Administered _____.

Number of Times/Intervals Medication is to be Administered _____.

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

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 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 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 have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent's Printed Name Tel

_____ _____

Parent's Signature Date