WICKLIFFE CITY SCHOOLS
Medication Administration Record (MAR)

Place student photo here

PHYSICIAN AND PARENTS REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

The prescribed medication shall be received in its original container in which it was dispensed and labeled with the name of the student, medication, dosage, time interval of administration and doctor's name. Over the counter medication needs to be provided in its original packaging with safety seal intact. All medication must be delivered to the school by the parent or guardian.

Name of student____

Address of student____

School______________________________________Grade_____________________________

Medication and dosage____

Time of day to be administrered____

Number of times/intervals the medication may be administered________________________

Special instructions____

Adverse reaction that should be reported____

Reason for giving this medication____

Medication to be administered from__________________________to__________________________
(Date) (Date)

_______________________________ _______________________________
Physician's Signature Physician's telephone number

_______________________________ _______________________________
Physician's Printed Name Date

PARENT'S PERMISSION FOR ADMINISTRATION OF MEDICATION

I hereby give my permission for____
(Student's Name)
to take the above medication at school as ordered from ____________________to____________________

_______________________________ _______________________________
Parent/Guardian Signature Date

This form must be completed in its entirety.

04/2022