OVER THE COUNTER PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

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

Student Photo

School _____ Grade/Rm: _____

Student _____ DOB _____

Address _____

City/State/Zip _____

Name of Medication and Dose _____

Reason For Medication _____

Times/Intervals Medication is to be Administered _____

Date to Begin Medication _____ Date to End Medication _____

Special Instructions for Administration of Medication _____

Adverse/Severe Reaction that Should be Reported to Physician _____

Physician/Health Care Provider Name and Phone Number _____

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

Parent/Guardian:
I give permission for my child to receive this medication at school according to the school district policy.
I agree for child's healthcare provider to talk with the school about this medication if needed.
I agree and am responsible to:

- Deliver this medicine to school in its original container.
- Tell the school as soon as possible if there is a change in the use of this medicine.
- Complete a new medicine form for this medicine if there are dose changes.
- If medication dosage does not match the instructions on original container, a healthcare provider order is required.

_____ _____

Parent/Guardian Printed Name Tel

_____ _____

Parent/Guardian Signature Date

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