

**PRESCRIBER AND PARENT REQUEST
FOR THE ADMINISTRATION OF MEDICATION
AT SCHOOL**

(Medication Administration Record – MAR)

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

Student
Photo

School _____

Student _____ DOB _____ 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

Rev. 4/2020 Reviewed by Dr. Carly Wilbur