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 _____ Dose_____

Time 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 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 Telephone number

_____ _____

Prescribers Signature Date

Please regard my signature below as my assurance that I _____ release Cuyahoga Heights Schools, employees, PSI or PSI 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 time prescribed. I also agree to keep the school informed in writing of any revisions in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent/Guardian Printed Name Telephone number

_____ _____

Parent/Guardian Signature Date