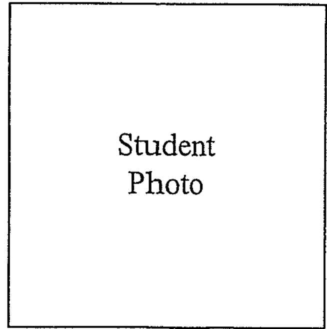
Fax 330-773-9100

PRESCRIBER AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

(Medication Administration Record – MAR)

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



School Archbishop Hoban High 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

Meds must be in original container or box.