Washington, D.C. May 21-23, 2025

Medication Administration Record (MAR) **ONE medication per form**

Student Information

Student Name		DOB
School	Year	
Known Allergies	Height	Weight

Prescriber Information

Name of Medication **ONE** PER FORM		Reason for Use	
Dosage	Route	Frequency	
Special Instructions			
Prescriber Signature			Phone
Prescriber Name (print)		Date	Fax

Licensed Health Provider **Sign**

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.
☑ Medication form must be received by the principal, designee, and/or the school nurse. ☑ I understand the medication must be in the **original** container and be properly labeled with the student's name, name of medication, dosage, and strength.

Parent/Guardian Signature	Date	#1 Contact Phone	#2 Contact Phone

Parent Sign

Parent/Guardian Self-Carry Authorization (if applicable)

☐ ***For Epinephrine Auto Injector:*** *As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

☐ ***For Asthma Inhaler:*** *As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian Signature	Date	#1 Contact Phone	#2 Contact Phone

*******STAFF USE ONLY***** Medication Documentation Record (MDR) *****STAFF USE ONLY*******

Month	May		
Day	**21st**	**22nd**	**23rd**
Time given and initals			

Nurse/Staff Signature ________________________________ **Initials** ____________