ANTHONY WAYNE LOCAL SCHOOLS

INHALER/NEBULIZER-MEDICATION ADMINISTRATION RECORD (MAR)

Completed form can be FAXED to: ____________________

	School year

Student Information

Student Name			Date of birth
Student address			
School	Grade	Homeroom teacher	
List any known drug allergies/reactions			

Prescriber Authorization for Inhaler (please☑)

Name of medication	Reason

Standard Order: ☐ per MDI ☐ per nebulizer ☐2 puffs ☐4 puffs ☐6 puffs PRN(As Needed) ▫ with spacer
Every : ☐ 4 hours ☐4-6 hours PRN (As needed) for cough, wheeze, tightness in chest, difficulty breathing or shortness of breath;
May repeat in: _____ minutes x _____ if no improvement for a total of ____ times

☐ **Pre-Exercise**: 2 puffs via MDI 5 to 20 minutes before exercise

☐ **Daily Dose**: Specify time ________________am/pm Time Interval: every __________hours as needed

Date to begin medication	Date to end medication
Special Instructions	

Authorization is hereby given for the student named above to (please ☑):

☐ As the prescriber, I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in the proper us of the inhaler.

☐ Receive the prescribed medication indicated from the designated school personnel.

Prescriber signature	Date
Prescriber name	
Phone	Fax

Parent/Guardian Authorization

☑ I understand that according to Anthony Wayne Board of Education Policy 5330 (Use of Medication) this form must be completed by the prescribing physician and parent prior to administration of prescription medication by designated school personnel. ☑ I authorize a designated employee of the Anthony Wayne Board of Education to administer the above medication. ☑ I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. ☑ I understand that additional parent/prescriber statements will be necessary if the dosage or time or interval of the medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. ☑ I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration. ☑ **I understand it is in the best interest of my child to have a "back-up" asthma inhaler available at the designated school health clinic or office for emergencies.**

Parent must ☑below to indicate student is allowed to self-carry their inhaler

☐ I authorize and recommend self-medication by my child for the prescribed listed medication

☐ I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician.

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

Please contact the school for any questions or concerns

5330 F3