

ANTHONY WAYNE LOCAL SCHOOLS
PRESCRIPTION MEDICATION-MEDICATION ADMINISTRATION RECORD (MAR)

Completed form can be FAXED to: _____

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

Prescriber Authorization

Name of medication		Reason
Dosage	Route	Time/Interval
Date to begin medication		Date to end medication
Treatment in the event of an adverse reaction		
Special Instructions		
Prescriber signature		Date
Prescriber name		
Phone		Fax

Parent/Guardian Authorization

<input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> I authorize a designated employee of the Anthony Wayne Board of Education to administer the above medication. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> I understand that additional parent/prescriber statements will be necessary if the dosage or time or interval of the medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. <input checked="" type="checkbox"/> 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 when appropriate. <input checked="" type="checkbox"/> I also understand that a responsible adult must deliver/pick-up the medication to/from school.		
Parent/Guardian Signature		Date
#1 Contact phone	#2 Contact phone	

Please contact the school for any questions or concerns