ANTHONY WAYNE LOCAL SCHOOLS

EPINEPHRINE-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 for Epinephrine Autoinjector Administration *

Note ORC requires a "back-up" epinephrine autoinjector is available at the designated school health clinic or office for emergencies. ORC 3313.718(3)

Name and dosage of medication		Reason
Date to begin medication	Date to end medication	
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief		
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 autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.**		
☐ **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 that Ohio law requires a "back-up" epinephrine autoinjector is available at the designated school health clinic or office for emergencies.** {ORC 3313.718(3)}

Parent must ☑ below to indicate student is allowed to self-carry their epinephrine autoinjector		
☐ **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 (available at all times)	#2 Contact phone	

Please contact the school for any questions or concerns