Atkinson 419-334-6749
Croghan 419-332-4314
Lutz 419-334-5499
Otis 419-334-6788

FREMONT CITY SCHOOLS
parent authorization form for medication

FMS 419-334-5494
Fremont Ross 419-334-5450

Medication Administration Record (MAR)
General Medication Form
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name			Date of birth
Student address			
School	Grade/Class	Teacher	School year
List any known drug allergies/reactions		Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	

Circumstances for use

Special instructions

Treatment in the event of an adverse reaction

Epinephrine Autoinjector
- ❑ Not applicable
- ❑ Yes, 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.

Asthma Inhaler
- ❑ Not applicable
- ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.

Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718
a) To the student for whom it is prescribed (that should be reported to the prescriber)

b) To a student for whom it is not prescribed who receives a dose

Other medication instructions
Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No

Prescriber signature	Date	Phone	Fax

Prescriber name (print)

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ 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.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

❑ *For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, 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

❑ File per district policy

FREMONT CITY SCHOOLS

Medication Documentation Record (MDR)

Student name	❑ Male ❑ Female Date of birth	Home address	Student ID#	Photo
Grade/Class	Teacher	School		
Parent/Guardian name	Parent/Guardian emergency contact numbers (include all)			
Best Safe Practice: ❑ (Triple check) right student, right medication, right dose, right time, right route (compare with Medication Administration Order/MAR) ❑ Medication in original container/prescription bottle				

Medication name:	Begin date:	End date (if known):	Discontinued order date:
Medication dosage:	Possible adverse reactions:		
Medication time:	Special instructions:		

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

Nurse/staff signature	Initials

X = No school
AB = Absent
ER = Error
O = No medication available
F = Field trip
H = Hold

Notes:

Medication Count

Medication name	Arrival date	Initial count	Wasted amount and date	Parent notified Yes or No	Count sent home and date

ghh100721

❑ File per district policy

FREMONT CITY SCHOOLS

Medication Inventory Record

Note best practice: ALL medication received at the designated school location will be logged in/out and recorded on the Master Inventory Record.

- Each individual student's medication count will also be recorded on each student's Medication Documentation Record (MDR)
- Medication unaccounted for must be reported per school district policy

Sign in date	Medication name	Rx number	Quantity	Expiration date	Sign out date	Date returned to parent/guardian	Wasted date per guidelines	Administrator or RN signature	Witness signature (parent or school staff)

ghh100721

❑ File per district policy

FREMONT CITY SCHOOLS

Medication Incident Report

Student Information

Student name		Student ID
Date of birth	Age	Weight
School	Grade/Class	Teacher

Incident

Date of Incident	Time of Incident	Reported by (name and title)

Type of Incident (☑ Check if applicable)

❑ Unable to locate student	❑ Incorrect route	❑ Medication outdated
❑ Student refused medication	❑ Incorrect transcription	❑ Medication bottle mislabeled
❑ Incorrect student	❑ Incorrect technique	❑ Omitted dose(s)
❑ Incorrect time	❑ Medication wasted	❑ Possible adverse reaction
❑ Incorrect dose	❑ Medication not available	❑ Other_____

Description of incident above

Contacted

☑ Check if applicable	Time	By Whom
❑ Healthcare provider		
❑ School nurse or RN		
❑ Parent/guardian		
❑ School administrator		
❑ Unable to contact parent/guardian		
❑ 911		
❑ Poison Control (800-222-1222)		

Student Outcome (☑ Check if applicable)

❑ Return to class	❑ Sent home with parent/guardian
❑ Refer to physician's office	❑ Refer to Urgent Care
❑ Admitted to hospital	❑ Refer to Emergency Department
❑ 911 called	❑ School days missed _____
❑ Other _____	

Signature

Form completed by	Title	Date
School nurse	Title	Date
School administrator/principal	Title	Date

ghh100121

❑ File per district policy