GRANVILLE CHRISTIAN ACADEMY

Prescription Medication Administration Record (MAR)

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			
Circumstances of use			
Dosage	Route		Time/Interval
Date to begin medication		Date to end medication	
Possible Severe Adverse Reactions/			
Treatment in the event of an Adverse Reaction			
Procedures for school employees if the medication does not produce the expected result/relief			
Other Medication instructions Does the medication require refrigeration? ☐ Yes ☐ No Is the substance a controlled substance? ☐ Yes ☐ No			
Prescriber Signature	Date	Phone	Fax
Prescriber name (print)			

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. I give permission for the school's licensed healthcare provider to share my child's pertinent health information and emergency action plan with school staff when deemed necessary regarding the administration of these medications during the school day.

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