

Medication Administration Record (MAR)

General Medication Form

(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name	Date of birth
Student address	
Miami University	Program
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 university 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

<p>I authorize an employee of Miami University to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of 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.</p> <p>Medication form must be received by the administrator, his/her designee, and/or the 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.</p> <p>I, for myself, my heirs, executors, administrators and assignees, hereby release and hold harmless TriHealth, Inc., its subsidiaries and affiliates, and its respective physicians and staffs from any and all claims, liabilities or demands of any kind arising from the administration of or failure to administer medications.</p>			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

<p><i>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.</i></p> <p><i>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.</i></p>			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone