ADMINISTRATION OF MEDICATION
PRESCRIBER AND PARENT REQUEST
ST. ANTHONY OF PADUA
(Medication Administration Record – MAR)
***** **One Medication per Form** *****

Name of Student: _____Age:____Grade/Rm: _____

Student Address: _____

Name of Parent/Guardian (**print**):_____Phone:_____

1. Name of Medication:_____Dose:_____
2. If medication is to be given EVERYDAY/DAILY, at what time(s):_____
3. How soon can it be repeated if necessary (Frequency):_____
4. If medication is to be given only when needed, describe indication/symptoms: _____
5. Possible side effects:_____
6. Date to Begin Medication: _____Date to End Medication: _____

Special Instructions for Administration and storage of Medication: _____

Parent Signature needed for ALL over-the-counter AND prescription Medications:

I request and give consent to any employee of the School who has been authorized to administer the medication listed below to my child. I will comply with Ohio law which requires me to **deliver the medication to the school in its original container**. I understand that it is not the responsibility of school personnel to remind my child to take the medication. Please regard my signature below as my assurance that I release the School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription.

Parent/Guardian Signature: _____Date:_____

Physician Signature needed ONLY for PRESCRIPTION Medications:

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

Physician Name (Print):_____

Physician Address_____

Physician Phone: _____

Physician Signature: _____ Date: _____