Four County Career Center
Medication Administration Record (MAR) for Prescription Medications
(ALSO FOR EPI PENS AND ASTHMA INHALERS)

The following section is to be completed by the **PARENT/ GUARDIAN**:

Student name	Birth date	School Year
Address	City	Grade/program
List any known drug allergies	Height	Weight

****PARENT/GUARDIAN AUTHORIZATION****

I authorize an employee of the school board to administer the medication. I also authorize the Licensed School Nurse to talk with the prescriber or pharmacist to clarify medication orders.
Medication form must be received by the designated person and/or 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.

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

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****PHYSICIAN/PRESCRIBER AUTHORIZATION****

Prescriber name	Address	Emergency phone number

Name of medication	Circumstances for use:
Dosage	Route
Time/ Interval	Start and end time for medication:
Special instructions	
Possible severe adverse reactions to observe (to be reported to prescriber):	
Milder reactions:	

Other information:

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_____ _____ _____

Prescriber's signature **Date** **Fax number**