

**PRESCRIBER AND PARENT REQUEST  
FOR THE ADMINISTRATION OF MEDICATION  
AT SCHOOL**

(Medication Administration Record – MAR)

\*\*\*\*\* One Medication per Form \*\*\*\*\*

Student  
Photo

School \_\_\_\_\_

Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade/Rm \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Name of Medication and Dosage \_\_\_\_\_.

Times of Day to be Administered \_\_\_\_\_.

Number of Times/Intervals Medication is to be Administered \_\_\_\_\_.

Date to Begin Medication \_\_\_\_\_ Date to End Medication \_\_\_\_\_

Adverse/Severe Reaction that Should be Reported to Physician \_\_\_\_\_

Special Instructions for Administration of Medication \_\_\_\_\_

This medication can be safely administered by non-medical personnel ☐ Yes ☐ No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours ☐ Yes ☐ No

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.

\_\_\_\_\_  
Prescriber's Printed Name

\_\_\_\_\_  
Tel

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date

Please regard my signature below as my assurance that I release \_\_\_\_\_ 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. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

\_\_\_\_\_  
Parent's Printed Name

\_\_\_\_\_  
Tel

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

Rev. 4/2020 Reviewed by Dr. Carly Wilbur