[MEDICATION ADMINISTRATION REQUEST AND CONSENT FORM

MEDICATION ADMINISTRATION REQUEST FORM-MAR

One medication per form

This form is required for the administration of prescription medication, "over-the-counter" medication (OTC), and alternative/herbal supplements by Timothy School Responsible Personnel.

For completion by Parent/Guardian

Student Name: ______________________________________ DOB: __________________

Last *First*

The Timothy School requests that medication(s) should be given at home before or after school. When this is not possible, the parent/guardian and the Licensed Prescriber must complete the *Medication Administration Request and Consent Form (MAR).*Medications must be provided to the school on the original pharmacy labeled container or original container for "over-the-counter" (OTC) medications and alternative/herbal supplements. Medication should be delivered and picked up by the parent/guardian. Parents/Guardians are responsible for noting expiration date of medication as listed on the medication label and providing a new prescription when medication has expired, changed or has run out. **Medication forms expire at the end of each academic year and must be renewed.**

Special Note for Emergency Medications (Epipen, Clonazepam, "rescue" asthma inhaler, Diastat): Parent/Guardian and Licensed Care Provider should first complete this form (MAR). In addition, individualized Emergency Care Plans should be completed by parents/guardians and treating physician.

I, ____ authorize the Responsible Personnel to

Name of parent/guardian (print)

Administer the Medication____ as ordered

Print name of Medication

by the licensed prescriber to my child.

____ ______________

Signature of parent/guardian *Date*

I give the school nurse and/or consulting Timothy School Psychiatrist consent to exchange health information with the prescribing doctor as it relates to student's condition, medication and/or treatment plan. I can withdrawal this consent in writing at any time. Consent valid for 2017-2018 school year, including ESY (extended school year).

____ ______________

Signature of parent/guardian ***Date***

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For Completion by Licensed Prescriber (Medication Order)

Special instructions for prescriber regarding orders for emergency epinephrine auto injector:

If you prescribe two doses of epinephrine for auto injection for symptoms of anaphylaxis, please specify the time frame between doses.

Name of Student: ______________________________ **DOB:** _________

Diagnosis for which medication is prescribed: ____

Name of Medication: ____

Route: ____

Time of administration/Frequency__________________________________

Possible side effects/adverse reactions: ____

Start Date__________ **Discontinuation Date:** __________

Specific instructions regarding administration: ____

____

Allergies: _____________________________________

____

Printed name of Licensed Prescriber *Phone Number:* _______________

____ ______________________

Signature of Licensed Prescriber *Date*

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