General Medication Administration Record (MAR)

www.4KidHelp.com

4KidHelp, Inc.

Center for Child & Adolescent Psychiatry

4368 Dressler Rd NW . Canton, Ohio 44718 . Phone: (330) 433-1300 . Fax: (330) 494-0828 . email: info@4KidHelp.com

PARENT FILLS OUT

Student Information

Student name			Date of birth
Student address			
School	**Grade**	**Teacher**	**School Year**
List any known drug allergies or reactions			

Parent/Guardian Authorization

☒	I authorize an employee of the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the licensed school healthcare professional to talk with the prescriber or pharmacist to clarify medication order(s).
☒	I understand that the medication must be in the **original** container and be properly labelled 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 expiration.

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

PRESCRIBER FILLS OUT

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	**Route**	**Time/Interval**
Date to begin medication - ☐ Today's date ☐ First day of school this year	**Date to end medication** ☐ Last day of school this year	

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** ☐ None

b) **To a student for whom it is not prescribed who receives a dose** ☒ Seek immediate medical attention

Can the student carry own medication ☐ Yes ☐ No	**Special instructions**
Is the medication a controlled substance? ☐ Yes ☐ No	☐ None
Does the medication require refrigeration ☐ Yes ☒ No	

Prescriber Authorization

Prescriber name (print)	4KidHelp, Inc., Suite #103, 4368 Dressler Rd NW, Canton, OH 44718 Phone 330-433-1300 Fax 330-494-0828
Prescriber signature	**Date**