

Asthma Medication Administration Record (MAR) Part 1

(Parent/Guardian signature required on Part 2) A completed form must be provided before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Student address	Student ID#
Grade/Class	Date of birth	School	Student Photo (Must attach)
	Teacher		

Medication order in this section must be signed by the prescriber

Medication Name & Start /End Date	Dosage Route & Time Interval	Possible Severe Adverse Reactions	Special Instructions (Choose all that are appropriate)
<p>1. Medication: _____</p> <p>Albuterol HFA _____</p> <p>Brand (circle): Pro Air, Ventolin, Proventil _____</p> <p>Levalbuterol HFA _____</p> <p>Brand (circle): Xopenex _____</p> <p>1. Asthma Diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, list Diagnosis: _____</p> <p>Asthma Severity: _____</p> <p><input type="checkbox"/> Intermittent</p> <p><input type="checkbox"/> Mild Persistent</p> <p><input type="checkbox"/> Moderate Persistent</p> <p><input type="checkbox"/> Severe Persistent</p> <p><input type="checkbox"/> Exercise</p> <p>Begin Date: _____</p> <p>End Date (if known): _____</p>	<p>2</p> <p><input type="checkbox"/> Standard Order: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> 6 puffs PRN (as needed) via MDI every _____</p> <p><input type="checkbox"/> 4 hours <input type="checkbox"/> 4-6 hours PRN (as needed) for cough, wheeze, tightness in chest, difficulty breathing or shortness of breath</p> <p>May repeat in: _____ minutes x _____ if no improvement for a total of _____ times.</p> <p><input type="checkbox"/> Pre-exercise: 2 puffs via MDI 5 to 20 minutes before exercise</p> <p>Ordered inhalers with spacer _____ (spacer name)</p>	<p>3</p> <p>Possible Severe Adverse Reactions per Orc 3313.716</p> <p><input type="checkbox"/> To the student for whom it is prescribed (that should be reported to the physician)</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> To the student for whom it is NOT prescribed who receives a dose</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Other _____</p>	<p>4</p> <p>Special Instructions</p> <p><input type="checkbox"/> Student may carry medication and may self-administer (parent must complete Part 2)</p> <p><input type="checkbox"/> Provide training on proper inhaler use</p> <p><input type="checkbox"/> See Action Plan</p> <p><input type="checkbox"/> Procedures to follow if the medication does not produce the expected relief: _____</p> <p>_____</p> <p><input type="checkbox"/> Store medication in school health room and student to self-administer under observation.</p> <p><input type="checkbox"/> Store medication in school health room and designated school employee to administer</p> <p><input type="checkbox"/> Other: _____</p>
<p>2. Medication: _____</p> <p>Diagnosis: _____</p> <p>Begin Date: _____</p> <p>End Date (if known): _____</p>	<p><input type="checkbox"/> Standing Daily Dose</p> <p>Specify Time: _____ am and/or <input type="checkbox"/> pm</p> <p>Time Interval: every (q) _____ hours as needed</p> <p>_____</p> <p>(specify signs, symptoms or situations)</p>	<p>Possible Severe Adverse Reactions Reportable to Prescriber:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Special Instructions</p> <p><input type="checkbox"/> Store medication in school health room and designated school employee to administer</p> <p><input type="checkbox"/> Requires refrigeration</p> <p><input type="checkbox"/> Other: _____</p>
<p>3. Medication: _____</p> <p>Diagnosis: _____</p> <p>Begin Date: _____</p> <p>End Date (if known): _____</p>	<p><input type="checkbox"/> Standing Daily Dose</p> <p>Specify Time: _____ am and/or <input type="checkbox"/> pm</p> <p>Time Interval: every (q) _____ hours as needed</p> <p>_____</p> <p>(specify signs, symptoms or situations)</p>	<p>Possible Severe Adverse Reactions Reportable to Prescriber:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Special Instructions</p> <p><input type="checkbox"/> Store medication in school health room and designated school employee to administer</p> <p><input type="checkbox"/> Requires refrigeration</p> <p><input type="checkbox"/> Other: _____</p>
<p>List home medication(s)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>6</p> <p>Prescriber (please print): _____</p> <p>Prescriber Address: _____</p>	<p>6</p> <p>Prescriber Signature/Date: _____</p> <p>Prescriber Emergency Phone: _____</p> <p>Fax: _____</p>	<p>For Nurse Use Only: (Revision per Licensed Nurse after consultation with prescribing provider)</p> <p>_____</p> <p>_____</p> <p>_____</p>

Asthma Medication Administration Record (MAR) Part 2

Prescriber order(s) and signature required on Part 1. A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

A

Student Information

Student name	Date of birth
Student address	Grade/Classroom

B

Parent Authorization

- I authorize a designated employee of the school board to administer the prescriber's medication as ordered for my child.
- I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
- I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist should a question come up about the medication.
- Medication and medication form must be received by the principal, his/her designee, or the 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 when appropriate.
- I agree that it is important to keep a backup rescue asthma inhaler at the school's designated location.
- I understand I must come into the school office/clinic when my child's medication is discontinued by the prescriber at the end of the school year, or medication will be disposed of one week post discontinuation orders or school year end.

Parent/Guardian signature	Date	#1 contact phone ()	#2 contact phone ()
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C

Parent/Guardian Self-Carry Authorization

(Parent must below to indicate student is allowed to self-carry their inhaler)

- I authorize and recommend self-medication by my child for the prescribed listed medication.
- I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending prescriber.

Parent/Guardian signature	Date	Phone ()	Cell ()
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D

Do not write below (For school staff only)

Reviewed by	Title/Position	Date
Comments		