General Medication Administration Record (GMAR)

Do not use for seizure or diabetes medications.
This form does not replace standard individual healthcare plans.

Ohio Department of Health

STUDENT INFORMATION

Student Name:			Date of Birth:
Student Address:			Student Phone #(if applicable):
Parent/Guardian Name:			Parent/Guardian Phone #:
School:	Grade/Homeroom:	Teacher:	School Year:
List Any Known Drug Allergies/Interactions:		Height:	Weight:

PRESCRIBER AUTHORIZATION

Name of Medication:		Strength/Formulation:
Dosage:	Route:	Time/Interval:
Date to Begin Medication:	Date to End Medication:	
Circumstances for Use:		
Side Effects/Special Instructions:		
Treatment in the Event of an Adverse Reaction:		
Epinephrine Autoinjector:	☐ Not Applicable ☐ Yes, as the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student training in the proper use of the autoinjector.	
Asthma Inhaler:	☐ Not Applicable ☐ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.	
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief:		
Possible Severe Adverse Reaction(s) per ORC 3313.716 and 3313.718: a) To the student for whom it is prescribed (that should be reported to the prescriber): b) To a student for whom it is not prescribed who receives a dose:		
Other Medication Instructions:		Does medication require refrigeration? ☐ Yes ☐ No
Prescriber Signature:		Date:
Phone:	Fax:	Prescriber Emergency Phone #:
Prescriber Name and Address (Print):		

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.

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PARENT / GUARDIAN AUTHORIZATION AND SELF-CARRY AUTHORIZATION FOR EPINEPHRINE AND / OR INHALER

I authorize an employee of the board of education or governing authority 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 school employee or licensed healthcare professional to talk with the prescriber or pharmacist to clarify the medication order. I agree to submit a revised statement signed by the prescriber to the board or governing authority or a person designated by the board or governing authority if any of the information provided by the prescriber changes.

Medication form must be received by the principal, their designee, and/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.

Self-Carry Authorization for Epinephrine or Inhaler:

☐ For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

☐ For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent Guardian Signature:	Date:	#1 Contact Phone:	#2 Contact Phone:

Medication Documentation Record (MDR)

Ohio Department of Health

Student Name:	☐ Male ☐ Female ☐ Other Date of Birth:	Home Address:	Medication Description:	Photo:
Grade/Homeroom:	Teacher:	School:		
Parent/Guardian Name:	Parent/Guardian Emergency Contact Numbers (Include All):			
Best Safe Practice: ☐ Medication in original container/prescription bottle. ☐ (Triple check) right student, right medication, right dose, right time, right route (compare with Medication Administration Order/MAR)			Student Phone # (If Applicable):	

Medication Name:	Begin Date:	End Date (If Known):	Discontinued Order Date:
Medication Dosage:	Possible Adverse Reactions:		
Medication Time:	Special Instructions:		

Enter Time and Intials in the boxes below.

X = No school; AB = Absent; ER = Error; O = No medication available; F = Field trip; H = Hold

Day	August	Sept	October	Nov	Dec	Jan	Feb	March	April	May	June	July
1	AM / PM											
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												

Student Name: _____ Student Date of Birth: _____

Ohio Department of Health

Enter Time and Intials in the boxes below.

X = No school; AB = Absent; ER = Error; O = No medication available; F = Field trip; H = Hold

Day	August	Sept	October	Nov	Dec	Jan	Feb	March	April	May	June	July
15	AM / PM											
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												

NURSE / STAFF SIGNATURE AND INITIALS

Nurse Staff Signature	Initials	Nurse / Staff Signature	Initials
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

☐ File Per District Policy

Medication Inventory Record

Ohio Department of Health

Student Name: _____ Student Date of Birth: _____

Note Best Practice: ALL medication received at the designated school location will be logged in/out and recorded on the Master Inventory Record.

- Each individual student's medication count will also be recorded on each student's Medication Documentation Record (MDR).
- Medication unaccounted for must be reported per school district policy.

Sign-In Date	Medication Name	Rx Number	Quantity	Expiration Date	Sign-Out Date	Date Returned to Parent/Guardian	Wasted Date Per Guidelines	Administrator or RN Signature	Witness Signature (Parent or School Staff)

☐ File Per District Policy

Medication Incident Report

Ohio Department of Health

STUDENT INFORMATION

Student Name:		Date of Birth:
Student Address:		Student ID:
Age:	Weight:	Grade/Class:
School:		Teacher:

INCIDENT

Date of Incident:	Time of Incident:	Reported By (Name & Title):
Type of Incident (☑ Check if Applicable):		
☐ Unable To Locate Student ☐ Student Refused Medication ☐ Incorrect Student ☐ Incorrect Time ☐ Incorrect Dose	☐ Incorrect Route ☐ Incorrect Transcription ☐ Incorrect Technique ☐ Medication Wasted ☐ Medication Not Available	☐ Medication Outdated ☐ Medication Bottle Mislabeled ☐ Omitted Dose(s) ☐ Possible Adverse Reaction ☐ Other _____
Description of Incident Above:		

CONTACTED

☑ Check if Applicable:	Time:	By Whom:
☐ Healthcare Provider		
☐ School Nurse or RN		
☐ Parent / Guardian		
☐ School Administrator		
☐ Unable To Contact Parent / Guardian		
☐ 911 / EMS		
☐ Poison Control (800-222-1222)		

STUDENT OUTCOME (☑ Check If Applicable)

☐ Return to Class ☐ Refer to Physician's Office ☐ Admitted to Hospital ☐ 911 / EMS ☐ Other _____	☐ Sent Home with Parent / Guardian ☐ Refer to Urgent Care ☐ Refer to Emergency Department ☐ School Days Missed

SIGNATURE

Form Completed By:	Title:	Date:
School Nurse:	Title:	Date:
School Administrator / Principal:	Title:	Date:

☐ File Per District Policy