Seizure Medication Administration Record (SMAR)

Do not use for general 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 / TREATMENT PROTOCOL DURING SCHOOL

A) Daily / Routine In-School Medications:

Name of Medication:	Concentration / Formulation:	Dose:	Route:	Frequency or Time:	Side Effects / Specific Instructions:

Date to Begin Medication:	**Date to End Medication:**

Possible Severe Adverse Reaction(s):

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:

B) Does Student Have a Vagus Nerve Stimulation (VNS) Device? (Any Trained Adult Can Administer)

☐ No ☐ Yes, If YES Describe Magnet Use: _____ ☐ Swipe Magnet ☐ Immediately

☐ Within ____ min; if seizure continues, repeat after ____ min____ times: give emergency medication after_____ min and call 911 / EMS.

C) Emergency Medication(s) (List in Order of Administration) Call 911 / EMS Immediately After Administration.

Name of Medication:	Concentration / Preparation:	Dose:	Route:	Administer After:	Side Effects / Specific Instructions:
				MIN	
				MIN	

Procedures for School Employees if it does not Produce the Expected Relief:

Special Medication Instructions Including Definitions of Terms Such as a Cluster:

Does medication require refrigeration? ☐ Yes ☐ No

☐ Yes, as the prescriber, I approve for this student to possess this drug prescribed to prevent the onset of a seizure or to alleviate the symptoms of a seizure if conditions under ORC 3313.7117 are satisfied. ☐ Not Applicable

Prescriber Signature:	**Phone:**	**Fax:**	**Date:**

Prescriber Name and Address:

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PARENT / GUARDIAN AUTHORIZATION

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

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.

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

☐ File Per District Policy

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:**		

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												

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

Student Name: _____ **Student Date of Birth:** _____

Ohio Department of Health

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												

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

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**