



# FAIRVIEW PARK CITY SCHOOLS

## ADMINISTRATIVE OFFICES

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### PRESCRIBER AND PARENT/GUARDIAN REQUEST

For Administration of Medication at Fairview Park City Schools

[Medication Administration Record- MAR]

\*\*\*\*\* One Medication per Form \*\*\*\*\*

School: \_\_\_\_\_

Student: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Times of Day to be Administered (##:##AM/##:##PM): \_\_\_\_\_

Number of Times/Intervals Medication is to be Administered: \_\_\_\_\_

Medication Start Date: \_\_\_\_\_ Medication End Date: \_\_\_\_\_

Adverse/Severe Reaction to be Reported to Physician (DO NOT LEAVE BLANK):  
\_\_\_\_\_

Special Instructions for Medication (with/without food/liquid, DO NOT LEAVE BLANK):  
\_\_\_\_\_

This medication can be safely administered by nonmedical personnel? \_\_\_\_\_ YES \_\_\_\_\_ NO

***This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.***

Prescriber's Printed Name: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_

Prescriber's Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

***Please regard my signature below as my assurance that I release Fairview Park City Schools, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.***

Parent's/Guardian's Printed Name: \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_

Parent's/Guardian's Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_