## General Medication Administration Record (GMAR)



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

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 AUTHORIZAT	ION			
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			
	$\square$ 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 medica	ation or if it does not produce the expecte	ed relief:	
Possible Severe Adverse Reaction(s) per	ORC 3313.716 and 3313.718:			
a) To the student for whom it is prescri	bed (that should be reported to the presci	riber):		
b) To a student for whom it is not pres	cribed 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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#2 Contact Phone:

## 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.		

#1 Contact Phone:

Date:

Parent Guardian Signature: