

# Ohio Department of Health

## Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716/3313.14

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 symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student's name
Student address

**This section must be completed and signed by the student's parent or guardian.**

*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
Parent/Guardian Name	Parent/Guardian emergency telephone number (     )

**This section must be completed and signed by the student's physician.**

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Procedures for school employees if the medication does not produce the expected relief  _____	

**Possible severe adverse reactions:**

To the student for whom it is prescribed (that should be reported to the physician)
To a student whom it is <b>not</b> prescribed who receives a dose
Special Instructions  _____  _____

<b>Physician signature</b>	Date
Physician Name	Physician emergency telephone number (     )

Adapted from the Ohio Association of School Nurses

# Your Road Map to Asthma Medication Administration Record (MAR) Part 1

Ohio students must provide a completed form to the school principal and/or nurse before the student may possess and use an asthma inhaler at school or at any activity, event or program sponsored by or which the student's school is a participant.

The Asthma Medication Administration Record consists of two parts and may also include other forms including an Asthma Action Plan, Individualized Healthcare Plan, Individualized Education Plan, 504, etc. The following guide is number/color coded for parents, school staff and prescribers.

Please do your part to ensure that children get the medication they need.

## Guidelines for Completing Road Map

<p><b>Parent/Guardian:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Part 1: Complete <b>Section A</b></li> <li><input type="checkbox"/> Part 2: Complete Sections <b>A</b> and <b>B</b>. Complete <b>Section C</b> if applicable</li> <li><input type="checkbox"/> Attach a recent photo of your child to form</li> </ul>	<p><b>School Staff:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review parent/guardian and prescriber sections for completeness in <b>Columns 1-6</b> and <b>Section A</b></li> <li><input type="checkbox"/> Keep extra blank forms available</li> </ul>
--	--

<p><b>Prescriber:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fill in the Prescriber's Order columns 1-6 (ensure that student's name and address is complete in <b>Section A</b>) <ul style="list-style-type: none"> <li><b>Column 1:</b> Include medication name(s), dates and list allergens. Complete an Asthma Action Plan to accompany the MAR form so families/school can follow treatment plans and use medications correctly</li> <li><b>Column 2:</b> Provide specific indications (dosage, time) for administration of medications including PRN</li> <li><b>Column 3:</b> List possible severe adverse reactions</li> <li><b>Column 4:</b> Write any special instructions. Indicate if additional backup asthma inhaler has been prescribed to be kept at school</li> </ul> </li> <li><input type="checkbox"/> <b>Section 5:</b> List other home medications</li> <li><input type="checkbox"/> <b>Section 6:</b> Fill in prescriber's name and emergency contact information</li> </ul>
--

Asthma Medication Administration Record (MAR)			Student Photo
<b>A</b> Student Name, Sex, Date of Birth, Home Address, Student ID, Grade/Class, Teacher, School			
Medication Name and Start/End Date  1. Medication  <div style="text-align: center; font-size: 2em; font-weight: bold; color: red;">1</div>	Dosage, Route and Time Interval  Standard Order  <div style="text-align: center; font-size: 2em; font-weight: bold; color: blue;">2</div>	Possible Severe Adverse Reactions  <div style="text-align: center; font-size: 2em; font-weight: bold; color: teal;">3</div>	Special Instructions  <div style="text-align: center; font-size: 2em; font-weight: bold; color: red;">4</div>
2 Medication	Standing Daily Dose	Possible Severe Adverse Reactions	Special Instructions
3 Medication	Standing Daily Dose	Possible Severe Adverse Reactions	Special Instructions
List Home medications	Prescriber Address	Prescriber Signature:	For Nurse Use
5	6	6	

## Your Road Map to Asthma Medication Administration Record (MAR) Part 2

Part 2 of the Asthma Medication Administration Record must be completed by parents/guardians and school staff.

Please do your part to ensure that children get the medication they need.

Asthma Medication Administration Record (MAR)	
<b>Student Information</b>	<b>A</b>
<b>Parent/Guardian:</b>	
<input type="checkbox"/> Complete student information in Section A	
<b>Parent Authorization</b>	<b>B</b>
<b>Parent/Guardian:</b>	
<input type="checkbox"/> Complete Section B to authorize administration of medication(s) at school, in accordance with prescriber orders	
<b>Self-Carry Authorization</b>	<b>C</b>
<b>Parent/Guardian:</b>	
<input type="checkbox"/> Complete Section C to authorize your child to self carry and self administer asthma inhaler as prescribed	
<b>School Staff Only</b>	<b>D</b>
<input type="checkbox"/> Section D for use by SCHOOL STAFF only.	

# 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	Student address	Student ID#	Student Photo (Must attach)
Grade/Class	Teacher	School	

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

## 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 (    )
---------------------------	------	-----------------	----------------

## D

### Do not write below (For school staff only)

Reviewed by	Title/Position	Date
Comments		