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: