

**Mayville School District
Medical Consent Form**

****All over the counter medication must be in its original, sealed container with label intact**
Prescription medication must be in a properly labeled pharmacy bottle.
All medication must be supplied by parent**

Student's Name _____ Date _____

Home Phone _____ Parent Daytime Phone _____

Section I: For NON-PRESCRIPTION Medication

1. Name of Medication _____ Amount/Dose _____

Times to be given _____ Duration _____

Reason for Medication _____

2. Name of Medication _____ Amount/Dose _____

Times to be given _____ Duration _____

Reason for Medication _____

Section II: For Prescription Medications

*This portion must be completed by a physician, physician's assistant or nurse practitioner prior to the student taking medication at school. Medications will be stored and dispensed in the school's Main Office. The exception to this is epi-pens and inhalers, which may be carried by the student with physician and nurse written approval.

Medication	Route				Conditions Under Which to Medicate	Contact Physician When:
1)						
2)						
3)						

*Students with asthma inhalers or epi-pens for allergic reactions:

____ This student may carry and self-administer medication.

____ This student needs supervision and/or assist with administration.

I agree to retain power to direct, supervise, decide, inspect and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have questions.

Hospital/Clinic/Office: _____ Address: _____

Physician's Signature: _____ Phone#: _____ Date: ____/____/____

Section III: Parental Permission

I hereby give permission to the people named below to give the medication(s) to my child/ward according to the directions stated above and further authorize them to contact the child's physician. I agree that the school District, its employees and agents who act within the consent granted by this document, shall not be liable for any claims that I may have arising from the administration of this medication to my child/ward at school.

Signature of Parent/Guardian: _____ date ____/____/____

Address: _____ Phone#: _____

Administrative Authorization:

The following staff is authorized to dispense medication: designated office staff or school nurse

Principal's Signature: _____ date ____/____/____