

**School District of Mayville  
Medical Consent Form**  
**\*\*All must be in its original container with label intact\*\***

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	Dosage			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 \_\_\_/\_\_\_/\_\_\_