Date Received:_____
received:_____
Initials:_____

School Consent for Administration of Non-Prescription Medications
MACCRAY Public Schools

711 Wolverine Drive Clara City, MN 56222
Phone: 320-847-2154
Fax: 320-301-0932

Student Name _____ Date of Birth _____

School _____ Grade_____Teacher _____

Medical Provider Name:_____Clinic: _____

Medication	Strength	Dosage	Time	Route

Diagnosis/Medical reason for taking medication: _____

Other considerations/Directions:_____

Allergies? No Known_____Yes, please list_____

Start Date:_____ Stop Date:_____

*All medications must be supplied to the school in the ORIGINAL bottle.
No medications will be administered that are supplied to the school in unlabeled containers.

Parent/Guardian Permission

1. I request that the above medications(s) be given during the school hours.
2. I give permission for the school nurse to consult with the student's teachers about the student's health condition(s) and actions of the medication(s).
3. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
4. I release all school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of the medication.

Parent Signature_____ Date_____

All Authorizations expire at the end of the school year and must be re-signed annually