Consent for Self-Carry/Self-Administer
Non-Prescription Pain Relievers for grades 6-12 only.

MACCRAY Middle School and High School
711 Wolverine Drive
Clara City, MN 56222

Student: _____ **Date of Birth:** _____ **Grade:** _____

Allergies? No Known _____ **Yes, please list**_____

Medication

Medication: _____

Dosage: _____

Frequency: _____

Indication(s) for use: _____

Parent/Guardian Authorization

I request and authorize self-carry & self-administration of the above medication and assure that the student:

- Is knowledgeable about this medication and safe administration.
- Has the skills to safely possess and use this medication.

Parent/Guardian Signature: _____
Date: _____ Daytime Phone: _____

Student Agreement

I agree to:

- NEVER share medication with anyone else.
- Keep the medication in its original container.
- Follow the manufacturer's directions regarding dosage, frequency, and indications for use.
- Notify the nurse if my symptoms get worse or if I am experiencing a side effect from my medication.

Student Signature: _____ Date: _____

Nurses Signature: _____ Date: _____