Date Received:___
received: _____
Initials:_____

School Consent for Administration of 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:_____

Physician or Authorized Prescriber order

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

The student is both capable and responsible for self-administering this medication: (Subject to school policy)
No _____ Yes, Supervised_____ Yes, Unsupervised_____

Print name of Provider _____ Date _____

Provider Signature _____ Phone Number _____

*Prescriber: Please remind parent to get a labeled bottle from the pharmacy for school use.

Parent/Guardian Permission

1. I request that the above medications(s) be given during the school hours as ordered by the Physician/Licensed prescriber.
2. Prescription medication must be provided in an original pharmacy container with a current label.
3. I request the medications(s) to be given on field trips as prescribed. I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
4. I will immediately notify the school of any medication changes, i.e. dose change, medication change, discontinued, etc.
5. I give permission for the school nurse to consult with the above-named student's Physician/Licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition being treated by the medication(s).
6. 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).
7. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
8. 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 Prescription medications must have a current prescription label from the Pharmacy. (Ex. Inhalers need the prescription label) Please ask your pharmacist for an extra container for school.