For Office Use Only:
Date Received:_____
Received by (initials): _____
Approved (Y/N): _____

# ***NON PRESCRIPTION***

MACCRAY Schools

School Consent Form for Administration of ***Non-Prescription*** Medication

*Please be aware staff at school and 911 personnel may be informed of your child's diagnoses and medications when such knowledge would benefit their care or education.*

Parents of students requesting medication be administered during school hours by school staff are required to provide for the school:

1. A ***written parental release*** for the administration of medication and
2. The medication must be in the ***original*** container

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STUDENT'S NAME: _____ BIRTHDATE: _____
PARENT/ GUARDIAN: _____ GRADE/ Teacher: _____
SCHOOL: _____
Print Medical Providers Name and Clinic: _____
_____

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1. MEDICATION: _____

☐ Tablet/ Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other

If Other, Please Describe: _____

2. ROUTE, DOSAGE ***AND*** TIME of Administration: _____
3. ***REASON*** for Medication (***DIAGNOSIS***): _____
4. ***START DATE:_____STOP DATE:_____*** ☐ End of School year
5. ***Restrictions*** and/ or important ***Side Effects:*** ☐ **None Anticipated**

   ☐ **Yes, Please Describe: _____**
6. **Allergies:** ☐ **No known Allergies** ☐ **Yes, Please list: _____**

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**PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION**

I request that the above medication be given at school. I understand that I must provide this medication in the ***ORIGINAL*** container labeled with my child's name. I understand that the school will not assume responsibility for medications self-administered. I authorize my child's school to release and exchange information with their health care provider.

PARENT/ GUARDIAN Signature: _____ Date: _____
Home Phone _____Work Phone _____