Mayville School District
Medical Consent Form
****All must be in its unopened original container with label intact****
The School District can no longer supply over the counter medication.

Student's Name_____Date_____

Home Phone_____Parent Daytime Phone_____

Section I: For NON-PRESCRIPTION Medication

1. Name of medication:_____Amount/Dosage _____
2. Times to be given_____Duration_____

   Reason for Medication_____

Section II: Parental Permission

I hereby request 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: school nurse or designated office staff

Principal's Signature:_____date___/___/__

Date	Initials	Date	Initials	Date	Initials	Date	Initials