Medication Consent Form
PRESCRIPTION

Student Name: ____

____ Date: _______________________________
Parent or Guardian

____ Phone #: _____________________________
Address

____ Date of Birth: ________________________

Name of prescription medication: ____

Purpose (reason) for this medication: ____

When is medication needed? ____

How often and what amount? ____

Duration of medication: Date to start: ___________ Last date to be given: __________

Instructions on the administration of medication (i.e., take with water, milk, etc.): ___________

____

Reaction(s) that may occur, if known: ____

I request First Academy to administer the above medication to my child:
____________________________________ (student name)

____________________________________ ____________________________________
Signature of Parent or Guardian Physician's Signature
(Required) (Optional)

Prescription medication may be administrated at school by school personnel when such medication is necessary for school attendance. Medication must be brought to school by the parent, not the student. The prescription medication must be in the original container with a current date.