Medication Consent Form
NON - PRESCRIPTION

Student Name: _____

_____ Date: _____
Parent or Guardian

_____ Phone #: _____
Address

_____ Date of Birth: _____

Name of non-prescription medication: _____

Purpose (reason) for this medication: _____

When is medication needed? _____

How often and what amount? _____

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 **(Required)** | Physician's Signature (Optional)

Non-prescription medication may be administrated at school by school personnel when such medication is necessary for school attendance. The non-prescription medication form will remain in affect for the duration of the school year.