



**FAITH CHRISTIAN**  
A C A D E M Y

**WRITTEN MEDICATION CONSENT FORM**

One form must be completed for each medication. Multiple medications *cannot* be listed on one consent form. This form is valid for one school year. One school year is defined as the first day of school through the last day of Summer Camp. All medication must be presented in its original packaging along with any inserts describing side effects or special instructions.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Route of Administration: \_\_\_\_\_

Frequency to be Administered (*include time*): \_\_\_\_\_

Symptoms that Necessitate Administration (*must be observable and measurable*): \_\_\_\_\_

Side Effects to Medication: \_\_\_\_\_

What action should FCA take if side effects are noted? \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Reason for Medication (*unless confidential by law*): \_\_\_\_\_

Date to be Discontinued *or* Length of Administration: \_\_\_\_\_

Describe additional training, procedures, or competencies staff will need to care for this student: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

I authorize Faith Christian Academy (FCA) to administer the medication as specified above to the student as specified above. I have verified this form is complete where applicable. My signature indicates that all information needed to administer the medication as specified above has been given to FCA. I understand this form *expires on August 31<sup>st</sup> of each calendar year.*

Printed Name

Signature

Date

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