Keystone Local School District

ADMINISTRATION OF MEDICATION REQUEST

PARENT SECTION

Student Name _____ School _____

Address _____ Current Grade_____ School Year_____

1. Both the parent and the physician must complete this form. The physician must provide a detailed description of instructions, dosage levels, bad reactions, and other information.
2. Medication must be provided in the student's labeled prescription bottle. The label instructions must match the form instructions. If it is a non-prescription medication, it must be in the original container.
3. New forms must be submitted each school year for any medication dispensed at school. New forms must be submitted if the dose, time, etc. changes.

I request that medication be administered to my child according to the directions of the physician. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Parent/Guardian Signature _____ Date _____

PHYSICIAN SECTION

Student Name_____ Name of Medication_____

Strength _____ Dosage _____Time to be Taken _____

Start Date _____ End Date _____

Condition for which Medication is Requested _____

Possible Side Effects _____

Physician's Signature _____ Phone number _____

If medication (ex. Inhalers, Bee Sting Kits, etc.) is to be carried by the student, the back of this form must be completed by both the parent and physician.

From BOE Policy File: JHCD-R Rev. 1/2009

Keystone Board of Education
531 Opportunity Way
LaGrange, Ohio 44050
Phone: 440-355-2424
Fax: 440-355-4465

Keystone High School
580 Opportunity Way
LaGrange, Ohio 44050
Phone: 440-355-2400
Fax: 440-355-6017

Keystone Middle School
501 Opportunity Way
LaGrange, Ohio 44050
Phone: 440-355-2200
Fax: 440-355-6678

Keystone Elementary School
531 Opportunity Way
LaGrange, Ohio 44050
Phone: 440-355-2300
Fax: 440-355-4240

THIS SIDE TO BE COMPLETED ONLY FOR SELF-CARRY MEDICATIONS

PARENT SECTION

Student Name _____ School _____

Address _____ Current Grade _____ School Year _____

I request that my child, named above, be permitted to carry and self-administer the ordered medication. I take full responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of student, prescribing health care provider, strength and dosage of medication, and directions for use.

Parent Signature _____ Date _____ Phone _____

PHYSICIAN SECTION

Student Name _____ Name of Medication _____

Condition for which medication is administered _____

Time or indication for administration _____

Possible Side Effects _____

Duration (dates) of administration: _____ (current school year only)

IN MY OPINION, THIS PATIENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THIS MEDICATION.

Physician Name _____ Date _____

Address _____ Phone _____

Physician Signature _____