KEYSTONE
Local School District

ADMINISTRATION OF MEDICATION REQUEST

PARENT SECTION(Section 1)

Student Name _____ DOB _____ School KHS KMS KES
Circle One

Address _____ 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. *A new form must be submitted each school year for any medication that is to be dispensed at school. New forms must be submitted if the dose, time, etc. change.*

Parent Signature _____ Date _____

PHYSICIAN SECTION(Section 2)

Patient's Name _____ Name of Medication _____

Strength _____ Dosage _____ Time to be taken _____

Start Date _____ End Date _____

Condition for which medication is administered _____

Possible Side Effects _____

Physician's Name _____ Date _____
Please print

Address _____ Phone _____

Physician's Signature _____

From BOE Policy File: JHCD

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