KEYSTONE
Local School District

COMPLETE FOR SELF-CARRY MEDICATIONS

PARENT SECTION(Section 1)

Student Name _____ DOB _____ School KHS KMS KES
Circle One

Address _____ 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 the student, prescribing health care provider, strength and dosage of the medication, and directions for use.

Parent Signature _____ Date _____ Phone _____

PHYSICIAN SECTION(Section 2)

Patient's 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 the capability to carry and self-administer this medication.

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

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