# KEYSTONE LOCAL SCHOOLS

# ADMINISTRATION OF MEDICATION REQUEST

## PARENT SECTION

**Student Name _____Date of Birth _____ 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. **<u>New forms must be submitted each school year</u> 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 and Emergency Action Plans must be completed.**

*From BOE Policy File: JHCD Rev. 1/2009*

## COMPLETE FOR SELF-CARRY MEDICATIONS

## PARENT SECTION

**Student Name _____Date of Birth _____ 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 _____**

*From BOE Policy File: JHCD Rev. 1/2009*