KEYSTONE PREP MEDICATION AUTHORIZATION 2016-2017

Student Name: ____ Date: __________________

Prescribing Physician: ____ Phone: _________________

Emergency Contact: ____ Phone: _________________

MEDICATION SCHEDULE

MEDICATION	TIME	DOSAGE	M	T	W	TH	F

I authorize Keystone Prep High School's designated staff member to administer the medication listed above to my child at the times indicated above. The medication must be in the original prescription bottle with the appropriate dosage and time indicated on the label.

ALL CHANGES TO THE DOSAGE AND/OR TYPE OF MEDICATION MUST BE DONE IN WRITING.

____ ____________________________

Parent Signature Date

____ ____________________________

Clinic Supervisor Date

KEYSTONE PREP HIGH SCHOOL • 18105 GUNN HWY. • ODESSA, FL 33556
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