



KEYSTONE PREP MEDICATION AUTHORIZATION

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