

PRESCRIPTION MEDICATION REQUEST: SHORT TERM

STUDENT _____ SCHOOL _____

Note: Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

PARENT STATEMENT:

- I request that the following prescription medication be given to my child named above for not more than 15 school days.
- For this condition _____
- I understand that only current medications will be given at school.
- I understand that in the absence of the school nurse, other school personnel will administer the medication.
- I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner, in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements.
- I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.
- **I understand that this medication will be destroyed unless picked up by the end of the last student school day of the year.**

Medication _____ Dose _____

Time/dosage to be given _____

Begin Date _____ End Date _____

Possible Side Effects _____

Healthcare Provider _____ Phone _____

As parent/guardian of the above named student, I request the Anchorage School District to give medication to my child.

X _____

Parent/Guardian Signature

Date _____ Phone _____

School Nurse Signature

Phone _____ Fax _____

DATE	TIME	INITIALS
<i>Name/Initials</i>		
<i>Name/Initials</i>		