LONG TERM NON-PRESCRIPTION MEDICATION REQUEST

Student Name (Printed):_____Age: _____ Grade: _____ School I.D. # _____
Allergies (Medication): _____

As parent/guardian of the above named student, I request the School District to give medicine for the following condition(s) (***please circle all that apply***)
Condition: **Headache Cramps Dental Other: _____**

Medicine: **Acetaminophen Ibuprofen Naproxen Midol/Premsyn/Pamprin Other**
Dose: _____ Frequency:_____ Specify Time: _____ or As Needed:_____

I understand that the school is not legally obligated to administer medication to my child. Therefore, I agree to defend and hold harmless, the school district and its employees 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. Medication request must be deemed necessary to maintain or improve health and participation in the school program. Each request will be assessed for the most appropriate intervention and will be given at the standard dosage recommended by manufacturer. I will notify the nurse if I give this medication to my child before arrival at school while this request is in effect to prevent overmedicating. I agree to supply medication for my student in its original packaging (small bottles only, please). I also affirm that my child has taken this medicine at least two times in the past without any adverse side effects. **I understand that the medicine will be destroyed unless picked up by the end of the last student school day of this year. Medicines will not be kept by the school over the summer break per DEA regulations.**
Parent/Legal Guardian Signature: _____ Printed Parent Name: _____Date:_____

OVER THE COUNTER MEDICATION ADMINISTRATION RECORD

DATE~TIME~INITIALS	DATE~TIME~INITIALS	DATE~TIME~INITIALS	DATE~TIME~INITIALS	DATE~TIME~INITIALS	DATE~TIME~INITIALS

Initials_____ Name _____ Initials_____ Name _____

Initials_____ Name _____ Initials_____ Name _____

Nurse Notes:

Anchorage School District
Health Services Program