ANCHORAGE SCHOOL DISTRICT

HEALTH SERVICES

LONG TERM REQUEST FOR ADMINISTRATION OF PRESCRIBED MEDICATION

School personnel will assist parents by administering prescribed medication to students**.** **Medication sent to school without a pharmacy or manufacturer's label will not be given.** Medication must be in the original container indicating the following information: student name, dosage, health care provider, pharmacy, date issued, and prescription number. *This form or a written statement signed and dated by the health care provider is required for any medication given for more than fifteen days.*

PARENT STATEMENT School _____

I request that medication listed below be given to my child _____

I understand that a picture of my child will be placed on the medication card. I understand that in the absence of the school nurse, other school personnel may administer 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 it's 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 this year.***

Signature of Parent/Guardian_____Date_____

Home Phone _____Work/Emergency Phone_____

Name any other medications your child is taking _____

HEALTH CARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication.

_____should receive prescribed medication for the following

condition _____

Medication_____

Prescribed daily dosage _____

Time and dosage given at school_____

Beginning date of medication_____Ending Date_____

Possible side effects_____

Health Care Provider Signature _____Date _____

Print Name_____Phone_____

Health Care Provider Address_____

School Nurse_____ **Approved** ___ **Denied**____ **Date**_____

Phone_____**FAX**_____

ASD Form 317B (Revised 6/2003)