ANCHORAGE SCHOOL DISTRICT
HEALTH SERVICES

SHORT TERM PRESCRIPTION MEDICATION REQUEST

The Anchorage School District will assist parents whose health care provider has prescribed short-term prescription medicines for a period of time not to exceed fifteen days. **The medication must be delivered to the school in a labeled pharmacy container with the student name.** *ONLY CURRENT PRESCRIPTIONS WILL BE GIVEN AT SCHOOL.*

Name of Student _____ Age _____ Grade _____

Medication _____

Prescribed daily dosage _____

Time and dosage to be given in school _____

Beginning date of medication _____ Ending date _____

Possible side effects _____

Health care provider name _____ Phone _____

Pharmacy _____

Medication requests must be deemed necessary to improve or maintain student health and participation in the school program.

PARENT STATEMENT

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

_____

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 my the end of the last student school day of the year.***

X_____
Signature of Parent/Guardian

Date _____

Home Phone _____ Work Phone _____

School Nurse _____

Phone _____ FAX _____

Date	Time	Initials
Name/Int		
Name/Int		

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