Anchorage School District

Over-the-Counter (OTC)

Student:	DOB:	Grade:	Student ID:

Information

This form authorizes Anchorage School District nurses to administer FDA approved OTC medication(s) that do not require a prescription to obtain.

Over-the-Counter Medications

Dose and Frequency may NOT exceed drug label instructions

☐ **Acetaminophen** *(Tylenol)*
Reason:
Dose:
Frequency:

☐ **Ibuprofen** *(Advil, Motrin)*
Reason:
Dose:
Frequency:

☐ **Calcium Carbonate** *(Tums)*
Reason:
Dose:
Frequency:

☐ **Other OTC**: _____
Reason:
Dose:
Frequency:

Allergies ◯ No known allergies ◯ Allergic to: _____

Parent/Guardian Authorization

I consent to the administration of the over-the-counter medication(s) above. *I understand that the school is not legally obligated to administer medication to my child. Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the way it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar. I agree to supply medication for my child in its original packaging.* ***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 affirm that my child has taken this medicine at least two times in the past without any adverse side effects.*

Parent/Guardian:	Phone:	Date:
Signature:		

Nurse Delegation for UAP *(initialed and signed by delegating nurse)*

◯ _____ *I* ***AUTHORIZE*** *the delegation of this medication to the "Full UAP" as indicated on the UAP Training Log in accordance with 12 AAC 44.965. I acknowledge that I have assessed the student, and it is determined that they will not require an on-site assessment prior to future administrations of the medication(s) for the Reasons listed above. The UAP has been referred to the Drug Facts on the medication packaging for written instructions on storage, administration, dosing, measurement, and timing requirements; expected outcome (Purpose); contraindications (Do Not Use); interactions of medications (Ask a doctor…); unexpected outcomes (Stop use…) and what to do in the event of one; and will contact the nurse (or Healthcare Services when the nurse is unavailable) in the event symptoms worsen or do not improve, or in the event of an unexpected outcome.*

◯ _____ *I* ***DO NOT AUTHORIZE*** *the delegation of this medication.*

Nurse:	Initials:
Signature:	Date

This authorization expires at the end of the current school year.