



Anchorage School District  
**NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION AUTHORIZATION**

STUDENT  
PHOTO

|           |            |      |                            |
|-----------|------------|------|----------------------------|
| LAST NAME | FIRST NAME | M.I. | DATE OF BIRTH (MM/DD/YYYY) |
| SCHOOL    |            |      | GRADE                      |

**PERMISSION TO ADMINISTER NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION AT SCHOOL**

Medication requests must be deemed necessary to maintain or improve the child's health and participation in the school program. Each request will be assessed by the nurse for the most appropriate intervention, and **the child will be given the standard dosage recommended by the manufacturer.**

**I consent to the administration of the non-herbal, non-homeopathic over-the-counter medication(s) below.** 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 manner in which 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.**

Non-Prescription (Over-The-Counter) medication(s) to be given at school: \_\_\_\_\_

Reason for medication(s): \_\_\_\_\_

|                                  |                       |                  |
|----------------------------------|-----------------------|------------------|
| PARENT / GUARDIAN NAME (PRINTED) | RELATIONSHIP TO CHILD | TELEPHONE NUMBER |
| PARENT / GUARDIAN (SIGNATURE)    |                       | DATE             |