ANCHORAGE SCHOOL DISTRICT

MEDICATION REQUEST LONG TERM **PRESCRIPTION**

STUDENT _____ ***BIRTHDATE*** _____ ***SCHOOL*** _____

Note: Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

PARENT STATEMENT: I request that the prescription medication listed below be given to my child named above.

- 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 trained 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 its employees for any liability arising out of these arrangements.
- **I will notify the school immediately if the medication is changed.**
- I give permission for exchange of confidential information or consent for release of health information between medical provider below and school district regarding this medication as part of the provision of my child's care.
- **I understand that this medication will be destroyed unless picked up by the end of the last student school day of this year per federal DEA requirements.**

Parent/Guardian Signature _____ ***Date*** _____
Parent/Guardian Printed Name _____
Home phone _____ ***Cell Phone*** _____ ***Work/Emergency Phone*** _____
Other medications your child is taking _____
_____

HEALTHCARE 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. The above named child 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** _____

Healthcare Provider Signature _____ ***Date*** _____
Printed Name _____ ***Phone*** _____
Healthcare Provider Address _____