



ANCHORAGE SCHOOL DISTRICT

MEDICATION REQUEST: **SHORT 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 following prescription medication be given to my child named above for not more than **15 school days**.
- For this condition _____
- I understand that only current medications will be given at school.
- 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.**
- I give permission for exchange of confidential information or consent for release of health information between medical provider 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 the year.**

Medication _____ Dose _____
 Time/dosage to be given _____
 Begin Date _____ End Date _____
 Possible Side Effects _____
 Healthcare Provider _____ Phone _____

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

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Printed Name _____

Home phone _____ **Work/Emergency Phone** _____

Date	Time	Initials	Date	Time	Initials
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					
Name/Initials		Name/Initials			
Name/Initials		Name/Initials			