ANCHORAGE SCHOOL DISTRICT

MEDICATION REQUEST: SHORT TERM PRESCRIPTION

STUDENT _____ **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 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 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.

X_____ **Date** _____ **Phone** _____
Parent/Guardian Signature

_____ **Phone** _____ **Fax** _____
School Nurse Signature

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		