ANCHORAGE SCHOOL DISTRICT
SHORT TERM MEDICATION REQUEST—OUT OF DISTRICT TRAVEL

USE FOR:	PRESCRIPTION MEDS	EMERGENCY MEDS
	INHALERS	OVER THE COUNTER MEDS

The Anchorage School District will assist students or parents of students whose health care provider has prescribed short term medicines not to exceed the duration of the trip. **The medication must be delivered by parent/guardian in a labeled pharmacy container with the student name.** *ONLY CURRENT PRESCRIPTIONS WILL BE ADMINISTERED. (Must include over the counter medications such as ibuprofen, Tylenol, etc.)*

STUDENT NAME: _____ **DOB:**_____ **GRADE:**_____ **SCHOOL:** _____

MEDICATION NAME	DAILY DOSAGE		TIME TO BE GIVEN			BEGIN DATE	END DATE	POSSIBLE SIDE EFFECTS
	AM	PM	AM	PM	OTHER			
1.								
2.								
3.								
4.								
5.								

Health Care Provider: _____ Phone: _____

Pharmacy: _____

Medication requests must be deemed necessary to improve or maintain student health and participation in the school program.

Students may self -carry emergency medications only (Asthma or Anaphylaxis).

PARENT STATEMENT:

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

I understand that, in the absence of the nurse, other trained Anchorage School District ("ASD") personnel may administer this medication. Employees and agents of 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 NEGLIGENCE. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD employees and agents 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 conclusion of this field trip, unless I pick up the remaining medication(s) at the conclusion of this trip.

Parent/Guardian (Printed name):_____

Parent/Guardian Signature:_____Date:_____

Telephone: (Home)_____(Cell)_____(Work)_____

Email:_____

School Nurse Signature _____ **Phone** _____ **FAX** _____

Over ⇨

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Medication Administration Tracking Chart
Please Print Clearly

First medication Description: _____

Date	Time	Initials	Date	Time	Initials

Second medication Description: _____

Date	Time	Initials	Date	Time	Initials

Third medication Description: _____

Date	Time	Initials	Date	Time	Initials