ANCHORAGE SCHOOL DISTRICT

MEDICATION SELF-CARRY AUTHORIZATION

STUDENT ________________________________ **SCHOOL** ________________________
ACTIVITY ________________________________ **GRADE** ___________________________

The Anchorage School District permits a responsible, trained student to carry and/or self administer medication that has been prescribed or ordered by a physician to stay on or with the student due to a pressing medical need. This requires written order of health care provider with prescriptive authority, parent request, **and** school nurse approval.

PARENT STATEMENT

As parent/guardian of ________________________________, I permit him/her to carry and self administer the below ordered medication. I take responsibility for this permission and verify that my child has been trained in the proper administration of this medication including when to take it, the appropriate dosage, how to manage the side effects, what to do in an emergency. My child understands not to share this medication with anyone else. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use. ***I will notify the school immediately if the medication is changed and understand that the nurse may contact the physician or pharmacist regarding this 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 and coaches for any liability arising out of these arrangements.

Parent/Guardian Signature ____ ***Date*** __________________

Home Phone ___________________________ ***Work/Emergency Phone***__________________________

Other medications your child is taking ____

____

Student acknowledges the requirements ____

Student Signature

HEALTHCARE PROVIDER STATEMENT

This medication is required during and after school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. This child should receive prescribed medication for the following
Condition_ _______________________________**Medication**_____________________________________
Dosage______________________ **Time & Dosage during activity**: _________________________________
Side effects to be noted/reported ____
Other recommendations____
Beginning Date ______________________________ **Ending Date** __________________________________

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATIONS.

Healthcare Provider Signature______________________________________ **Date** _________________
Print Name ____ **Phone number** _______________________
Healthcare Provider Address

SCHOOL NURSE SIGNATURE ___________________________ **DATE** _____________ ☐ **APPROVED** ☐ **DENIED**