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MEDICATION SELF-CARRY AUTHORIZATION FOR SPORTS OR AFTER SCHOOL

STUDENT _____ **SCHOOL** _____
ACTIVITY _____ **GRADE** _____

The Anchorage School District and Alaska law (AS 14.30.141) permit a responsible, trained student to carry and/or self administer prescription labeled medication for Asthma, Anaphylaxis (severe allergic reaction), or Diabetes on his/her person for immediate use in a life-threatening situation upon 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 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**