Anchorage School District

Herbal Supplement

Student:	DOB:	Grade:	Student ID:

Information

It is the policy of the Anchorage School District that herbal supplements may be dispensed in school only when deemed necessary by a healthcare provider. This form must be signed by the prescribing health care provider **AND** a pharmacist.

To be dispensed by the school nurse, herbal supplements must:

- ✓ Be in an original, unopened package with the manufacturer's seal intact
- ✖ NOT be a compounded supplement or controlled substance under state or federal law.

Order

Herbal Supplement:	Dose:	Route:
Frequency:	Start Date:	End Date:
Indication:		
Current Medications:		
Adverse Reactions:		
Special Instructions:		

Ordering Provider:	NPI:	Phone:
Signature:		Date:

Pharmacy Verification

The above identified medications and herbal supplements have been reviewed for adverse effects or interactions with food, medications, or other substances. There are no known adverse reactions to report.

Pharmacist:	NPI:	Phone:
Signature:		Date:

Parent/Guardian Authorization

I hereby give permission for my child to receive the above listed herbal supplement at school and or during school sponsored activities, as prescribed by my child's healthcare provider and reviewed by a pharmacist. Permission is also given for the school nurse to contact the healthcare provider or pharmacist regarding this treatment. I understand all herbal supplements will be administered by the school nurse, or in the absence of a school nurse, any trained Unlicensed Assistive Personnel. 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 way it is administered, including for NEGLIGENCE. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar.

Name:	Phone:	Date:
Signature:		

All signatures must be present for this form to be valid.
This authorization expires at the end of the current school year.

Supplement:	Student:	ID:

Nurse Delegation for UAP *(initialed and signed by delegating nurse)*

◯ _____ *I **AUTHORIZE** the delegation of this herbal supplement to the "Full UAP" as indicated on the UAP Training Log in accordance with 12 AAC 44.965. I acknowledge that I have assessed the student, and it is determined that they will not require an on-site assessment prior to future administrations of the medication(s) for the Reasons listed above. The UAP has been referred to the Drug Facts on the medication packaging for written instructions on storage, administration, dosing, measurement, and timing requirements; expected outcome (Purpose); contraindications (Do Not Use); interactions of medications (Ask a doctor…); unexpected outcomes (Stop use…) and what to do in the event of one; and will contact the nurse (or Healthcare Services when the nurse is unavailable) in the event symptoms worsen or do not improve, or in the event of an unexpected outcome.*

◯ _____ *I **DO NOT AUTHORIZE** the delegation of this herbal supplement.*

Nurse:	Date:
Signature:	Initials:

FOR OFFICE USE ONLY

Inventory Control

Use this form to help manage medication inventory when receiving, returning, or otherwise adjusting medication.

- **Herbal supplement must be delivered by or returned to a parent/guardian.**
- Healthcare Services recommends accepting no more than a month's supply at a time.
- The Witness Signature can be the Parent/Guardian dropping the herbal supplement off or another ASD staff member.

Date	Time	Qty Received	Qty Returned/ Wasted	Total On Hand	Nurse Signature	Witness Signature