Anchorage School District

Long Term Prescription

Student:	DOB:	Grade:	Student ID:

Information

This form authorizes Anchorage School District nurses to administer prescription medications that will be given in school for 16 days or longer.

Long Term Prescription Order

To be completed by the prescriber

Medication:			Reason:
Dose:	Route:	Frequency:	Time:
Give PRN if morning dose missed at home ◯ YES ◯ NO			
Start Date:	End Date:	Notes:	

Prescriber:	NPI:	Phone:
Signature:		Date:

Parent/Guardian Authorization

I request that the prescription medication listed above be given to my child. 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 way 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 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.

Prescription medication must be delivered by the parent/guardian in the original pharmacy labeled packaging with the student's name, medication name, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.

Parent/Guardian:	Phone:	Date:
Signature:		

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

◯ _____ *I **AUTHORIZE** the delegation of this medication 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 medication.*

Nurse:	Date:
Signature:	Initials:

This authorization expires at the end of the current school year.

Medication:	Student:	ID:

FOR OFFICE USE ONLY

Inventory Control

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

- **Medication 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 medication off or another ASD staff member.

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