Anchorage School District

Out of District Travel

Student:	DOB:	Grade:	Student ID:

Information

This form is to be used for prescription-, emergency-, and over-the-counter medications while a student is on an ASD sponsored out-of-district activity that falls outside of regular school hours.

Out of District Travel Medications

Transcribe from the original prescription label – prescriber signature NOT required. Include daily, emergency, and OTC meds.

Medication	Time	Dose	Route	Reason	Notes
1. RX#:	AM: PM: Other:	AM: PM: Other:			Qty dispensed to UAP: ____
2. RX#:	AM: PM: Other:	AM: PM: Other:			Qty dispensed to UAP: ____
3. RX#:	AM: PM: Other:	AM: PM: Other:			Qty dispensed to UAP: ____
4. RX#:	AM: PM: Other:	AM: PM: Other:			Qty dispensed to UAP: ____
5. RX#:	AM: PM: Other:	AM: PM: Other:			Qty dispensed to UAP: ____
Healthcare Provider:				**Phone:**	

Parent/Guardian Authorization

As parent/guardian of the student above, I request the Anchorage School District to give the above medication 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.

Prescription medication must be delivered by the parent/guardian in the original pharmacy labeled packaging with the student's name, medication name, dosage, route, time, ordering provider, pharmacy, 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 conclusion of travel.

Anchorage School District

Out of District Travel

Student:	DOB:	Grade:	Student ID:

FOR USE BY THE UAP DURING OUT OF DISTRICT TRAVEL

Medication Administration Record

Medication Preparation

1. Confirm the Medication Authorization form for medication name, reason, dose, and frequency (how often the medication can be given)
2. Familiarize yourself with the drug facts label of the medication you're giving, expected outcomes, contraindications, unexpected outcomes and what to do in the event of one.

Prior to Administration

1. Ask the student to verify their name and birthdate *(if verbal)*
2. Ask what medication they're requesting and reason *(if OTC or emergency and verbal)*

Following Administration

1. Log all medications administered below.
2. Return this form to the school nurse when trip is completed.

Call the nurse or Healthcare Services at 742-4136 with any questions

Date	Time	Medication	Initials

Date	Time	Medication	Initials

UAP Name:	UAP Signature:	UAP Initials:
UAP Name:	UAP Signature:	UAP Initials: