Anchorage School District

Short-Term Prescription Medication Authorization

Student Photo

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

PHARMACY LABEL ORDER

MEDICATION	DOSE	ROUTE	TIME	INDICATION	START	END *Max 15 days from Start
MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)					PHONE	

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the prescription medication listed above be given to my child for no longer than 15 school days. I understand after these 15 days a prescription medication authorization will need to be completed by a medical provider with prescriptive authority in Alaska, in order for my child to receive additional doses of this medication. 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 manner in which 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 in the original pharmacy container labeled with the following information: name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.

PARENT/GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	PHONE
PARENT/GUARDIAN SIGNATURE		DATE

THIS AUTHORIZATION EXPIRES 15 DAYS FROM THE START DATE