MEDICATION REQUEST—OUT OF DISTRICT TRAVEL--SECONDARY

USE FOR: ***PRESCRIPTION MEDS*** ***EMERGENCY MEDS***
INHALERS ***OVER THE COUNTER MEDS***

The Anchorage School District will assist students or parents of students whose health care provider has prescribed short-term medicines not to exceed the duration of the trip. **The medication must be delivered in a labeled pharmacy container with the student name.** *ONLY CURRENT PRESCRIPTIONS WILL BE ADMINISTERED. (Must include over the counter medications such as ibuprofen, Tylenol, etc.)*

Student Name: _____			**Age: ___**		**Grade: _____**			**School:** _____		
	Daily Dosage		**Time to be given**					**Begin**	**End**	**Possible**
Medication Name	**AM**	**PM**	**AM**	**PM**	**Other**			**Date**	**Date**	**Side Effects**
1										
2										
3										
Healthcare Provider: _____								***Phone***: _____		
Pharmacy: _____										

Medication requests must be deemed necessary to improve or maintain student health and participation in the school program.

****Epipens/Twinjects & an Allergy Action Plan MUST be supplied by parents for ALL KNOWN anaphylactics.**

PARENT STATEMENT

As parent/guardian of the above named student, I request the Anchorage School District to give medication to my child for the following condition _____

I understand that in the absence of the school nurse (ie, during a field trip), other school personnel will administer the 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 for any liability arising out of these arrangements. **I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.** ***I understand that this medication will be destroyed unless picked up by the conclusion of this trip.***

Parent/Guardian Signature: X_____

Home Phone _____ Work Phone_____

Notarization of Parent Signature for out of district Travel Only:

State of Alaska _____ Judicial District Subscribed and sworn to (or affirmed) before me at _____(city), by _____(signer's name-Parent/Guardian)

on _____(date).

_____

Notary Public's Signature

My Commission Expires: _____

School Nurse Signature _____Phone _____ FAX _____