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: ________________________

Medication Name	Daily Dosage		Time to be given			Begin Date	End Date	Possible Side Effects
	AM	PM	AM	PM	Other			

Healthcare Provider: ____ Phone: __________________

Pharmacy: ____

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

<u>Epipens/Twinjects and an Allergy Action Plan MUST be supplied by parents for ALL KNOWN anaphylactics.</u>**

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. *<u>I understand that this medication will be destroyed unless picked up by the conclusion of this trip.</u>***

Parent/Guardian Signature: ____
Home Phone: ______________________________________ Work Phone: ________________________

School Nurse Signature: ______________________ Phone: __________________ FAX: ______________

Medication Tracking Chart
Please Print Clearly

1st Medication Description: ______________________________

Date	Time	Initials	Date	Time	Initials

2nd Medication Description: ______________________________

Date	Time	Initials	Date	Time	Initials

3rd Medication Description: ______________________________

Date	Time	Initials	Date	Time	Initials