ANCHORAGE SCHOOL DISTRICT
HEALTH SERVICES

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

The Anchorage School District permits a responsible, trained student to carry and/or self administer prescription labeled medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation upon written order of health care provider with prescriptive authority, parent request, and school nurse approval.

PARENT STATEMENT: School____

As parent/guardian of ________________________________ , I permit him/her to carry and self-administer the below ordered medication. I take responsibility for this permission and verify that my child has been trained in the proper administration of this medication including when to take it, the appropriate dosage, how to manage the side effects, what to do in an emergency, and understands not to share this medication with anyone else. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use. ***I will notify the school immediately if the medication is changed and understand that the nurse may contact the physician or pharmacist regarding this 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 it's employees for any liability arising out of these arrangements.

Signature of Parent/Guardian________________________________Date________________

Home Phone _________________________ Work/Emergency Phone____________________

Name any other medications your child is taking _____________________________________

Student Signature____ Date _______________

HEALTH CARE PROVIDER STATEMENT: ***This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication.***

_______________________________ should receive prescribed medication for the following condition____

Medication____

Prescribed daily dosage____

Time and dosage to be given in school ____

Side effects to be noted/reported____

Other recommendations____

Beginning date of medication ___________________ Ending date ________________________

<u>In my opinion , this student shows capability to carry and self-administer the above medications.</u>

Health Care Provider Signature______________________________ Date ________________

Print Name _______________________________________ Phone number _________________

Health Care Provider Address ____

School Nurse Signature _______________________ Approved___ Denied ___ Date _________

ASD HS Form902 (6//2005)