FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
520 Fifth Avenue Fairbanks, AK 99701-4756
(907) 452-2000

REQUEST FOR ADMINISTRATION OF MEDICATION
Long Term Medication

MUST BE COMPLETED ANNUALLY

When this form is completed and signed by the Health Care Provider and returned to the school nurse, the Fairbanks North Star Borough School District may assist parents when their child requires prescribed medication during the school day. The medication **MUST** be in the original pharmacy container labeled with the student's name, dosage, time of administration, prescribing physician, pharmacy, and current date.

I understand that this medication will be disposed of unless parent/guardian picks up by the end of the last student day of school.

Student ______________________________________ Birthdate ______________________ Grade _______

Parent/Guardian________________________________ Phone ______________________________________

TO BE COMPLETED BY HEALTHCARE PROVIDER

Medication _______________________________________ Diagnosis _____________________________

Dosage and Time of Administration ____

Discontinue Medication On ___________________________________

Other Medications Student is Taking ____

Physician____Date ____________________

Physician's Signature ____Phone____________________

PARENT/GUARDIAN ACKNOWLEDGEMENT

I, the parent/guardian of the above-named student, request that the school district administer the above medication as prescribed by my healthcare provider. I understand that in the absence of a school nurse, other trained unlicensed school personnel may administer this medication.

I will notify the school immediately if the medication is changed and understand that the nurse may contact the healthcare provider or pharmacist regarding this medication.

Parent/Guardian Signature __________________________________ Date ____________________

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520 Fifth Avenue Fairbanks, AK 99701-4756
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MEDICATION ADMINISTRATION: ASTHMA/ANAPHYLAXIS

Request for Self-Administration of Medication for Asthma or Anaphylaxis (Inhalers or Auto-Injectable Epinephrine)

MUST BE COMPLETED ANNUALLY

When this form is completed and signed by the Health Care Provider and returned to the school nurse, the Fairbanks North Star Borough School District may assist parents when their child requires prescribed medication during the school day. The medication **MUST** be in the original pharmacy container labeled with the student's name, dosage, time of administration, prescribing physician, pharmacy, and date.

Student____Birthdate_____________________Grade __________

Parent/Guardian_________________________________Phone _______________________________________

TO BE COMPLETED BY HEALTH CARE PROVIDER

Diagnosis ____

Medication__________________________Dosage & Time of Administration _____________________

- I certify that the above named student has asthma or a condition that may lead to anaphylaxis and has received instruction in the proper and safe method of self-administration of this medication.
- **[ ]** This student has demonstrated the skill level necessary to use this medication and any device that is necessary to administer the medication as prescribed.

Physician ____Date______________________________

Physician's Signature __________________________________Phone ____________________________

PARENT/GUARDIAN ACKNOWLEDGMENT

I, the parent/guardian of the above named student, **do [ ] do not [ ]** request that the school district permit he/she to carry and self-administer the medication prescribed by the health care provider. I agree not to institute suit against the school district or its employees or agents for injury arising from self-administration or storage of this medication and agree to indemnify and hold harmless the school and its employees or agents for any claims out of the self-administration or storage of this medication.

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 when epinephrine is administered either by the school nurse or the student, emergency medical services will be called.

Parent/Guardian Signature____Date ____________________