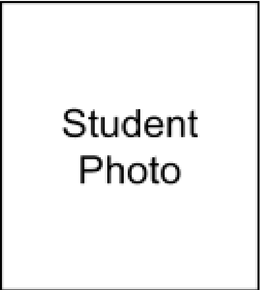
Fairbanks North Star Borough School District
Long-Term Prescription Medication Authorization



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

MEDICAL PROVIDER AUTHORIZATION

MEDICATION	DOSE	ROUTE	TIME	INDICATION	START

THIS ORDER EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

This medication is required during school hours to improve or maintain the health of this child. The school nurse may contact me regarding this medication.

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	PHONE
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the prescription medication listed above be given to my child. I understand and approve that, in the absence of Health Services personnel, other Fairbanks North Star Borough School District (“FNSBD”) personnel may be trained in the administration of this medication and administer this medication. Employees and agents of FNSBSD strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD 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 FNSBSD as part of the provision of my child’s care. I agree for Health Services personnel to share health information with FNSBSD 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 FNSBSD school year calendar.

Prescription medication must be in the original pharmacy container labeled with the student's name, dosage, time of administration, prescribing physician, pharmacy, current date and delivered by the parent/guardian to the Health Services office. Under no circumstance should medications be brought to school by the student (minor).

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

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