Dear Parent/Guardian,

Recent updates in statewide school health recommendations and guidelines have led to some changes in Anchorage Public School's medication policies. These changes will primarily affect over-the-counter medications. Beginning this school year, we must have a provider order and a parent permission on file before administering any medication to your child, including over-the-counter medication.

In an effort to ease this process, we have arranged to have a few select medications available to your child at school with standing orders for use at standard age & weight based doses when the need arises. These medications include acetaminophen, ibuprofen, diphenhydramine, and antibiotic cream. If you would like your child to receive these medications as needed, you may complete the attached permission form, specifying which medication you give permission for your child to receive. You will not need to bring these medications in, as the school will provide these. No additional paperwork will be required from your child's provider for administration of these medications during the school day at standard dosages for age and indication. The nurse will contact you prior to administering these medications when need arises.

All other medications (prescription or over-the-counter) will require a separate permission form completed by the health care provider and signed by the parent. This form may be found on the Anchorage website or obtained from the school nurse. If you expect that your child may need any additional medications during the school day, please let us know.

You, as parent/legal guardian, may always bring and personally administer a dose of medication to your child during the school day.

We appreciate your understanding during this transition. As always, please reach out if you have any questions or concerns.

Thank you,

Susan Dilday
Anchorage Public School Nurse
susan.dilday@anchorage.kyschools.us
502-245-2121

OVER-THE-COUNTER STOCK MEDICATION PERMISSION FORM

I agree that my child may have the following medications during the school day if needed. (**Initial** next to medications you agree **may be administered**). Dosing will be in accordance with APS standing orders. These medications will be provided by the school. If your child has a need for these medications, you will be contacted. Dosing will not exceed 3 consecutive days without request for an order from the student's provider.

____ acetaminophen (oral)

____ ibuprofen (oral)

____ diphenhydramine (oral)
(6 years and older)

____ topical antibiotic ointment (polysporin)

____ No stock medication should be administered by school nurse or trained staff

Additional required information:

Student Name: _____ Date of Birth: _____/_____/_____

Student age: ____ years Grade: _____

Student weight: ____ pounds

My child has: _____ No known allergies

____ Known allergies (please list): _____

I give permission for my child, _____, to receive the medications indicated above at school, according to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication.

Parent/ Guardian Name (Printed): _____ Phone: _____

Parent Signature: _____ Date: _____