



# Fairbanks North Star Borough School District Short-Term Medication Authorization



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

OVER-THE-COUNTER (OTC) or PHARMACY LABEL ORDER <i>[excluding Tylenol (acetaminophen), Motrin/Advil (ibuprofen), Zyrtec (cetirizine), TUMS (antacid)]</i>						
MEDICATION	DOSE	ROUTE	TIME	INDICATION	START	END
					<small>*Max 10 school days from Start</small>	
MEDICAL PROVIDER NAME (PRINTED)					MEDICAL PROVIDER PHONE	

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION		
<p>I request that the OTC or prescription medication listed above be given to my child for no longer than 10 school days. I understand after these 10 school days a prescription medication authorization will need to be completed by a health care provider with prescriptive authority in Alaska, in order for my child to receive additional doses of this medication. I understand and approve that, in the absence of Health Services personnel, other trained Fairbanks North Star Borough School District ("FNSBSD") personnel may be trained in the administration of this medication and administer this medication to my child.</p> <p>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 expiration of this form 10 school days from its START date, unless I pick up the remaining medication(s).</p> <p><b>I agree to supply medication for my child in its original packaging. I will notify the nurse if I give this medication to my child before arrival at school, while this request is in effect, to prevent over-medicating. I affirm that my child has taken this medicine at least two times in the past without any adverse side effects. Prescription medication must be in the original pharmacy labeled container and delivered by the parent/guardian to the Health Services office. OTC medications, including cough drops, must be in the original labeled container and delivered by the parent/guardian to the Health Services office. Under no circumstance should medications be brought to school by the student (minor).</b></p>		
PARENT/GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	PHONE
PARENT/GUARDIAN SIGNATURE		DATE

**THIS AUTHORIZATION EXPIRES 10 SCHOOL DAYS FROM THE START DATE**  
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