



Anchorage School District

Herbal Supplement



Student:	DOB:	Grade:	Student ID:
----------	------	--------	-------------

Information

It is the policy of the Anchorage School District that herbal supplements may be dispensed in school only when deemed necessary by a healthcare provider. This form must be signed by the prescribing health care provider **AND** a pharmacist.

To be dispensed by the school nurse, herbal supplements must:

- ✓ Be in an original, unopened package with the manufacturer's seal intact
- ✗ NOT be a compounded supplement or controlled substance under state or federal law.

Order

Herbal Supplement:	Dose:	Route:
Frequency:	Start Date:	End Date:
Indication:		
Current Medications:		
Adverse Reactions:		
Special Instructions:		

Ordering Provider:	NPI:	Phone:
Signature:		Date:

Pharmacy Verification

The above identified medications and herbal supplements have been reviewed for adverse effects or interactions with food, medications, or other substances. There are no known adverse reactions to report.

Pharmacist:	NPI:	Phone:
Signature:		Date:

Parent/Guardian Authorization

I request that the prescription medication listed above be given to my child. In the absence of the nurse, I expressly authorize other trained Anchorage School District ("ASD") personnel to administer this medication. Employees and agents of ASD strive to provide treatment consistent with the appropriate standard of care but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the way 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 ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD 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 ASD school year calendar.

Name:	Phone:	Date:
Signature:		

**All signatures must be present for this form to be valid.
This authorization expires at the end of the current school year.**

Supplement:	Student:	ID:
-------------	----------	-----

FOR OFFICE USE ONLY

Inventory Control

Use this form to help manage medication inventory when receiving, returning, or otherwise adjusting medication.

- **Herbal supplement must be delivered by or returned to a parent/guardian.**
- Healthcare Services recommends accepting no more than a month's supply at a time.
- The Witness Signature can be the Parent/Guardian dropping the herbal supplement off or another ASD staff member.

[illegible]