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 _____