



Fairbanks North Star Borough School District

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT  
520 Fifth Avenue Fairbanks, AK 99701-4756  
(907) 452-2000

**MEDICATION ADMINISTRATION: ASTHMA/ANAPHYLAXIS**

**Request for Administration of Medication for Asthma or Anaphylaxis  
(Inhalers or Auto-Injectable Epinephrine)  
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 date.

Student \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

**TO BE COMPLETED BY HEALTH CARE PROVIDER**

Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_ Dosage & Time of Administration \_\_\_\_\_

- I certify that the above named student has asthma or a condition that may lead to anaphylaxis and has received instruction in the proper and safe method of self-administration of this medication.
- This student has demonstrated the skill level necessary to use this medication and any device that is necessary to administer the medication as prescribed.

Physician \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Phone \_\_\_\_\_

**PARENT/GUARDIAN ACKNOWLEDGMENT**

I, the parent/guardian of the above named student, **do  do not**  request that the school district permit he/she to **carry and self-administer** the medication prescribed by the health care provider. I agree not to institute suit against the school district or its employees or agents for injury arising from self-administration or storage of this medication and agree to indemnify and hold harmless the school and its employees or agents for any claims out of the self-administration or storage of this medication.

I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.

**I understand that when epinephrine is administered either by the school nurse or the student, emergency medical services will be called.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_