SITKA SCHOOL DISTRICT
http://sitkaschools.org

300 Kostrometinoff Street
Sitka, Alaska 99835
Phone: (907) 747-8622
Fax: (907) 966-1260

REQUEST FOR ADMINISTRATION OF MEDICATION

This request must be renewed annually or sooner if condition warrants.

School personnel **may agree** to honor parent requests for the administration of medication to students. Any medication sent to school without proper identification will not be given. All medication must be in the **original container and if prescribed by a health provider, must** indicate the following information: student name, dosage, physician, pharmacy, date issued, and prescription number.

Medication Type: (Check type)

- ☐ Over the Counter Medication
- ☐ Prescription (**The completed Health Care Statement below or a written statement signed and dated by the health care provider supporting this request is required for all prescribed medication.)**

PARENT STATEMENT:

I hereby request that _____ medication be given to my child, _____.
(Name of medication) (Student's Name)

I understand that the school is not legally obligated to administer medication to my child, but school personnel will administer the medication, if needed. I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed.

Signature of Parent/Guardian:_____ Date:_____

Home Phone:_____ Work/Cell Phone:_____

List any other medications your child is taking:

HEALTH CARE PROVIDER STATEMENT (Complete this section for prescribed medication only)

_____ must receive medication during school hours for _____.
(Student's Name) (Condition)

This medication must be given during school hours in order to maintain sufficient health and participation in the school program.

Medication Administration Information

Medication:

Dosage:

Frequency:

Possible Side Effects:

Health Care Provider's Signature: _____ Date: _____
Health Care Provider's (printed): _____
Address: _____ Phone: _____
_____

Office Only: Bldg. BES KGH BMS SHS PHS REACH
Please give to District Nurse for signature before filing.

Nurse's Signature: _____ Date: _____

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AUTHORIZATION, RELEASE AND INDEMNIFICATION FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION

This request must be renewed annually or sooner if condition warrants.

BY SIGNING THIS FORM YOU AGREE TO RELEASE THE DISTRICT FROM ANY AND ALL LIABILITY THAT MAY RESULT FROM YOUR CHILD'S SELF-ADMINISTRATION OF MEDICATION.

Child's Name: _____ Date of Birth: _____

Grade: _____

I, _____, consent for my child to self-administer the medication listed
(Parent/Guardian)

below in the manner prescribed by his/her physician in the attached medical authorization.

Medication: _____

Dosage: _____

Frequency: _____

By signing this consent form, I agree to release, indemnify, hold harmless, and defend the school, its employees or agents from and against any and all claims, losses, damages, costs, actions, judgments, expenses and liabilities of every kind and nature whatsoever, that are in any way connected with, arise from, or are claimed to arise from, the self-administration or storage of my child's medication.

_____
Parent/Guardian (print name)

_____ _____
Signature Date

Office Only: Bldg. BES KGH BMS SHS PHS REACH
Please give to District Nurse for signature before filing.

Nurse's Signature: _____ Date: _____

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AUTHORIZATION FOR THE POSSESSION AND SELF-ADMINISTRATION OF MEDICATION REQUIRED TO TREAT ASTHMA OR ANAPHYLAXIS

This form is to be filled out by your child's health care provider.

This request must be renewed annually or sooner if condition warrants.

_____ has been prescribed the medication listed below.
(Child's name)

Medication: _____

Dosage: _____

Frequency: _____

Administration of this medication is required for treatment of the child's _____.
(Medical condition)

I have instructed _____
(Child's name)

on the proper method of self-administration of the medication, and am satisfied that he/she has the skill level necessary to self-administer the medication and to use any device needed to administer it. The medication and any device needed for its administration should be handled as indicated below:

☐ Stored with the school nurse or other designated school official and self-administered in their presence.

☐ Kept in the child's possession and self-administered as needed.

_____ _____
Physician's name (print) Telephone number

_____ _____
Signature Date

Office Only: Bldg. BES KGH BMS SHS PHS REACH
Please give to District Nurse for signature before filing.

Nurse's Signature: _____ Date: _____