ASD Healthcare Services
NUR #0523 Page 1 of 1 Revised 4/2020

SCHZ]o[•MedMedhealth and participation in the school program. Each request will be assessed by the nurse
for the most appropriate intervention, and the child will be given the standard dosage recommended by the manufacturer.

I consent to the administration of the non-herbal, non-homeopathic over-the-counter medication(s) below. I understand that the school is not legally obligated to administer
medication to my child. Employees and agents of the Anchorage School District (“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 manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I agree for
 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 overmedicating. I affirm that my child has taken this medicine at least two times in the past without any adverse side effects.

Non-Prescription (Over-The-Counter) medication(s) to be given at school: ____

Reason for medication(s): ____

PARENT / GUARDIAN NAME (PRINTED) RELATIONSHIP TO CHILD TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)

DATE

STUDENT
PHOTO