Catholic Schools of Fairbanks

Long Term Prescription Medication Request

The Catholic Schools of Fairbanks will assist parents whose health care provider has prescribed long-term (more than ten days) prescription medication. The medication may only be self-administered if it is in the original bottle/container marked with the student's name, dosage, time of administration, physician, pharmacy, and date of purchase.

Student: _____ DOB: _____ Grade:_____

PHYSICIAN SECTION: (TO BE FILLED OUT BY THE PHYSICIAN)

Medication: _____ Diagnosis _____

Dosage and Time of Administration: _____

Discontinue Medication On: _____

Possible Side Effects: _____

_____

_____

Other Medication(s) Student is Taking: _____

Physician's Signature _____ Date _____

Physician's Phone _____

PARENT STATEMENT

As parent/guardian of the above named student, I request the Catholic Schools of Fairbanks to give medication to my child for the condition listed above. I understand that the school is not legally obligated to administer medication to the student and that in the absence of the school nurse, other school personnel will administer the medication. I agree to defend and hold CSF 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 and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I understand that this medication will be destroyed unless picked up by the end of the last student school day of the current school year. I give my permission for the exchange/release of medical information regarding my child's treatment.

_____	_____	_____
Parent/Guardian Printed Name	Signature	Date

PRESCRIPTION INFORMATION:

Physician's name: _____ Pharmacy: _____ Rx Number: _____

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