Catholic Schools of Fairbanks

# Short Term Prescription Medication Request

The Catholic Schools of Fairbanks will assist parents whose health care provider has prescribed short-term prescription medicines for a period of time not to exceed ten days. This medication must be delivered to the school in a labeled pharmacy container with the student name. All prescriptions must be current to be given at school.

**Name of Student**: _____ Grade:_____

Medication: _____

Given for the following condition: _____

Time and dosage to be given in school: _____

Beginning date of medication: _____Ending date:_____

Possible side effects: _____

Health care provider name: _____Phone: _____

Pharmacy and Prescription Number: _____

**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 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.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian Printed Name | Signature | Date |

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*edited 6/14/16*