BUCKEYE UNION SCHOOL DISTRICT

STUDENT MEDICATION PERMISSION FORM

Medication Requirements: **ALL medications** (***including Over-The-Counter (OTC) meds like cough drops or ibuprofen AND prescriptions like inhalers, Epipen, etc.***) require a permission form **EVERY school year**. *For dosage changes an updated form is required. A parent can terminate medications at any time.* ***A physician's order can be attached to this form if it provides required medication details and parent signs this form.***

Student: _____ Birth date: _____ Grade: _____

PARENT/GUARDIAN: Please review and sign AND provide a physician statement for medications at school (below or attach):

- **Medications** must be brought in original container AND ***student family*** is responsible for replacing expired or empty meds
- ***This form authorizes school nurse or health clerk to communicate with ordering physician regarding medications***
- *I understand the school nurse* ***IS NOT*** *on campus daily therefore designated school personnel will administer medication* which *requires parent/legal guardian to bring the medication as outlined by a physician's written authorization* and I will allow school personnel, pursuant to CA Education Code, Section 49423, to assist my child (student as listed above) by giving him/her the medication needed to be administered at school as set forth in a physician statement (below or attached).
- *I release BUSD and personnel from civil liability if the student suffers adverse reactions by medications*
- ***I understand that MEDICATIONS THAT ARE NOT CLAIMED ON LAST DAY OF SCHOOL WILL BE DISCARDED***

Parent/Legal Guardian Signature: _____ Date: _____

School Nurse Signature (order reviewed): _____ Date: _____

PHYSICIAN'S STATEMENT: This student should be given these medication(s) **Please complete additional form for additional meds**:

MEDICATION(s); EXACT NAME & route of administration	**DOSE**	**TIME** (daily meds)	**FREQUENCY** (PRN Meds)	**DURATION**	**DIAGNOSIS OR PLEASE include SYMPTOMS when to use medication**
1		□ _____AM □_____PM	□ PRN □ Other:	□ school year □ Other:	DX: SYMPTOMS:
2		□ _____AM □_____PM	□ PRN □ Other:	□ school year □ Other:	DX: SYMPTOMS:
3		□ _____AM □_____PM	□ PRN □ Other:	□ school year □ Other:	DX: SYMPTOMS:

Is student able to carry permissible medication (inhaler, epinephrine, insulin/glucagon): If YES, which one(s): Circle 1 2 3

Possible side effects or additional concerns: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

MD **PRINT** Name & Office: _____

- Blue Oak, 530-676-0164 x1830 Fax: 530-676-0758
  Health Clerk II Joy Clark, Nurse Tristan
- Buckeye, 530-677-2277 x1230 Fax: 530-672-1483
  Health Clerk II Rachel Kelly, Nurse Tristan
- Camerado, 530-677-1658 x1530, Fax: 530-677-9537
  Health Clerk Lesley Gentry, Nurse Tristan
- Oak Meadow, 916-933-9746 x2130, Fax: 916-933-9784
  Health Clerk Luz Shaw, Nurse Sandy
- Rolling Hills, 916-933-9290 x3030, Fax: 916-939-7454
  Health Clerk Bertha Chau, Nurse Sandy
- Silva Valley, 916-933-3767 x2730, Fax: 916-933-6389:
  Health Clerk Tara Nakano, Nurse Sandy
- Valley View, 916-939-9640 x3330, Fax: 916-939-5015
  Health Clerk II Mary Dietrich, Nurse Tristan
- William Brooks, 916-933-6618 x2430, Fax: 916-933-3910
  Health Clerk II Terri Hale, Nurse Sandy

BUSD MEDICATION FORM IS Based on California Education Code Section 49423: Administration of Prescribed Medication for Pupil*:*
Notwithstanding the provisions of Section 49422, any pupil who is required to take ANY medication while at school may be assisted by school personnel however, they must provide a written physician's statement detailing use of the medication (***including OTC***), and include the method, amount, timing, of the medication to be taken. Parental or guardian permission on our district form is also required. The written statement MUST be renewed annually OR if there are any changes to the given medication as initially prescribed.