

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		<input type="checkbox"/> ____AM <input type="checkbox"/> ____PM	<input type="checkbox"/> PRN <input type="checkbox"/> Other:	<input type="checkbox"/> school year <input type="checkbox"/> Other:	DX: SYMPTOMS:
2		<input type="checkbox"/> ____AM <input type="checkbox"/> ____PM	<input type="checkbox"/> PRN <input type="checkbox"/> Other:	<input type="checkbox"/> school year <input type="checkbox"/> Other:	DX: SYMPTOMS:
3		<input type="checkbox"/> ____AM <input type="checkbox"/> ____PM	<input type="checkbox"/> PRN <input type="checkbox"/> Other:	<input type="checkbox"/> school year <input type="checkbox"/> 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 | ♦ Rolling Hills, 916-933-9290 x3030, Fax: 916-939-7454
Health Clerk Bertha Chau, Nurse Sandy |
| ♦ Buckeye, 530-677-2277 x1230 Fax: 530-672-1483
Health Clerk II Rachel Kelly, Nurse Tristan | ♦ Silva Valley, 916-933-3767 x2730, Fax: 916-933-6389:
Health Clerk Tara Nakano, Nurse Sandy |
| ♦ Camerado, 530-677-1658 x1530, Fax: 530-677-9537
Health Clerk Lesley Gentry, Nurse Tristan | ♦ Valley View, 916-939-9640 x3330, Fax: 916-939-5015
Health Clerk II Mary Dietrich, Nurse Tristan |
| ♦ Oak Meadow, 916-933-9746 x2130, Fax: 916-933-9784
Health Clerk Luz Shaw, Nurse Sandy | ♦ William Brooks, 916-933-6618 x2430, Fax: 916-933-3910
Health Clerk II Terri Hale (Sub: Raffaella Avina), 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.