BERRYESSA UNION SCHOOL DISTRICT—HEALTH SERVICES

SCHOOL MEDICATION PERMISSION FORM (CEC 49423)

This form must be completed in order for school to administer the required medication. A new School Medication Permission form must be completed each school year for each medication, whether prescribed or over-the-counter, and must be renewed when there are any changes in the medication instructions (i.e., dosage, frequency, etc.) OR a change in the HealthCare Provider(HCP).

HCP AUTHORIZATION: TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER(HCP):

StudentName:_____Birthdate: _____School:_____Grade:_____

Medication Name: _____ Dose: _____ Start date_____End date_____

Reason for giving medication: _____

( ) Tablet/Capsule ( ) Liquid/Oral ( )Topical ( ) Inhaler ( )Nebulizer ( )Drops ( )Injection

Required Dose _____ Time(s) to be given at school: _____ ( )Daily ( )PRN

If PRN, frequency: _____ If PRN, for what symptoms_____

Relevant Side Effects: _____Additional Instructions_____

_____ I authorize designated school district personnel to assist the student with medication administration according to the above instructions.

_____***MD INITIAL***. _____***MD INITIAL***. I authorize this student must carry this emergency/otherwise necessary medication on his/her person. The student has been instructed in the proper administration of this medication, understands the appropriate dosage and possible side effects & is competent to safely self-administer this medication per the above written statement

Prescriber's Name & Title: _____

Telephone_____ Fax_____ Dr./Clinic

STAMP Prescriber's Signature: _____Date:___/_____/_____

PARENT/GUARDIAN CONSENT I give consent for designated school personnel to administer the above medication to my child per the instructions of the above Health Care Provider (HCP). I give my consent for exchange of information and communication directly between the HCP listed above or dispensing pharmacist & Berryessa USD School Nurse/staff, regarding the HCP's written statement or any other questions about the medication or medication administration. I understand that I may refuse consent for this permission at any time by notifying the school nurse in writing. I understand and agree to the following responsibilities regarding medication administration:

1. Prescription medication must be in a container labeled by the pharmacist or Health Care Provider (HCP).
2. Non-prescription medication must be in the original container with the label intact.
3. Parent/Guardian must bring the medication to the school and pick up any outdated or unused medication.
4. Pill splitting must be done by the Parent/Guardian prior to providing medication to school officials.
5. Parent/Guardian provides all materials or necessary equipment (measuring spoon, pill crusher) for medication administration.
6. Parent/Guardian will notify the school nurse/administrator & provide new consent for any changes to the above authorization.
7. Any modifications or changes to the above authorizations may only be made after written notification is received from the HCP.
8. Student may ONLY carry and self-administer medication with the completed"Self Administration of Emergency Medication Form" on file.

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Parent/Guardian Signature Parent/Guardian Print Name Daytime Phone Date