BERRYESSA UNION SCHOOL DISTRICT—HEALTH SERVICES

SCHOOL MEDICATION PERMISSION FORM (CEC 49423)

This form must be completed fully in order for schools to administer the required medication. A new School Medication Permission form must be completed each school year for each medication, and when there is a change in the student's authorized health care provider, or a change in the medication dosage, method by which the medication is required to be taken, or date(s) or time(s) the medication is required to be taken.

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

Student Name:______________________________Birthdate: ____________________ School:______________Grade:_______

Medication Name: _________________________________ Strength: _________ Start date__________ End date_______

Reason for giving medication: ____

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

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

If PRN, frequency: ______________________________ If PRN, for what symtpoms______________________________

Relevant Side Effects: ____Additional Instructions____________________________

FOR EPINEPHRINE AND INHALERS ONLY:

Epinephrine in Office **Only** ▢ Epinephrine Student will Carry ▢ Epinephrine **Both** in Office and Student Will Carry ▢

Inhaler in Office **Only**▢ Inhaler Student Will Carry ▢ Inhaler **Both** in Office and Student Will Carry ▢

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 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 principal 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 (e.g. measuring spoon, pill crusher) for medication administration.
6. Parent/Guardian will notify the school nurse/administrator and 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 NOT carry and self-administer medication (i.e., Epi-Pen /Inhalers) unless the district's "Self Administration of Emergency Medication Form" has been completed by the student and the parent.

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