



Loomis Union School District

3290 Humphrey Road, Loomis, CA 95650 (916) 652-1800

www.loomis-usd.k12.ca.us

Building Excellence in Education since 1856

Gordon T. Medd, Superintendent

Franklin Elementary

Phone: (916) 652-1818

Fax: (916) 652-1821

Penryn Elementary

Phone: (916) 663-3993

Fax: (916) 663-2127

Loomis Grammar

Phone: (916) 652-1824

Fax: (916) 652-1826

Loomis Basin Charter

Phone: (916) 652-2642

Fax: (916) 652-1822

Placer Elementary

Phone: (916) 652-1830

Fax: (916) 652-1832

H. C. Powers Elementary

Phone: (916) 652-2635

Fax: (916) 652-2679

Ophir Elementary

Phone: (530)855-3495

Fax: (530) 823-9101

SCHOOL MEDICATION FORM

Student Name _____ Date of Birth _____

Parent's Name _____ Phone (home) _____ Cell _____ Work _____

Emergency Contact Name _____ Phone (home) _____ Cell _____

To Be Completed By Health Care Provider:

Diagnosis/Significant Findings: _____

Allergies (Medication/Other substances) _____

<u>Name of Medication or Treatment</u>	<u>Reason</u>	<u>Dosage</u>	<u>Route</u>	<u>Time</u>	<u>Self-Carry? (Y/N)</u>	<u>Possible Side effects</u>

For Student with Severe Allergy – see LUSD Allergy Emergency Health Plan form

For Student with Asthma:

Does student need medicine before PE or sports? No Yes PRN

Albuterol Inhaler- _____ puffs with spacer, 15-20 minutes before exercise; Other quick relief medication _____

If symptoms of coughing, wheezing, signs of difficulty breathing or _____:

1. Give quick relief medication Albuterol Inhaler _____ puffs (with spacer? Y___/N___)
Other quick relief medication: _____ **Location of medication:** _____ (School to complete)

2. Have helper call guardian and school nurse

3. If symptoms do not improve, repeat in 5-10 minutes.

4. **Call 911** if you see any of the following: **Student having trouble walking or talking, stooped body posture, skin pulling in around collarbone and ribs with breathing, continuous coughing, or lips or fingernails turning gray, blue, or purple**
May give _____ puffs albuterol every 20 minutes (3 times maximum) until medical help arrives.

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance to CA state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for the maximum of one year. If changes are indicated, I will provide new written orders and authorization (may be faxed).

Health Care Provider Signature: _____ Date: _____

Address: _____ Phone: _____

To Be Completed By Parent: I authorize the school nurse and/or other trained school personnel to assist my child in taking his/her medications and treatments, and I authorize the nurse to consult with the Health Care Provider about my child's medical needs as necessary while my child is at school. I understand it is my responsibility to provide all medication, supplies and equipment and understand that if my child carries his own medication I should provide extra to be kept in the office in case needed.

Parent Signature: _____ Date: _____