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) 663-1943
Fax: (530) 823-9101

SCHOOL MEDICATION FORM

_____

Student Name | Birth Date | Grade

_____

Address | Best Contact: Phone #1 | Phone #2

Parent Consent

I (we), the undersigned, the parent(s)/guardians of the above named pupil, request the following medication be administered to my(our) child in accordance with the California Education Code 49423.5.

I will:
1. 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.
2. Notify the school nurse if there is a change in the pupil's health status or attending physician.
3. Notify the school nurse immediately and provide new consent for any changes in the doctor's orders.
4. I ACKNOWLEDGE THAT IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.

I authorize the school nurse to communicate with the authorized Health Care provider when necessary in regards to this specific medication and medical condition.

Parent/Guardian Signature_____ **Date**_____

TO BE COMPLETED BY HEALTHCARE PROVIDER:

1. **Diagnosis:** _____
2. **Medication:**_____
3. **Dose:** _____
4. **Method of Administration:** _____
5. **Time medication is to be given at school (or time range i.e. q2-4 hours)** _____
6. **Possible reactions or side effects of medication:** _____
7. **Possible side effects or reactions that need to be reported to the physician (e.g., allergic reaction and treatment):** _____

Authorized Consent

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).

Student has permission to carry emergency medication with him/her: YES_____ NO____

Physician's Signature _____ Date _____

Address _____Telephone _____