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Student's Last Name First Name Parent/Guardian Name and Contact Number

Bennett Valley Union School District

PHYSICIAN'S APPROVAL FOR MEDICATIONS FORM for the _____ School Year

This form is required **each school year** for students requiring prescribed and/or over the counter medication to be taken during school hours and/or during school related activities and fieldtrips. In accordance with California State Education Code section 49423, both **sides of this form are to be completed and signed by the physician** (or other health care provider who has the authority to prescribe medication), signed by the parent/guardian and returned or faxed to the school to remain on file for any student who requires medication(s) during the regular school day or on field trips.. Recent education code changes no longer allow school districts to administer any medication, even Tums, without a doctor's recommendation, to protect the child from possible adverse reactions. Without this form on file, we will not be able to administer **any** medication to your child (except "Epi-Pen" Epinephrine in the case of life threatening allergic reaction). Students may not carry medication on their person (only exceptions with doctor's approval—asthma inhaler may be carried at school if the child has been trained and has an Asthma Action Plan on file.

- **All** medication must be brought to the school by a parent who must also pick it up when outdated/unused.
- All medication must be in the **original** container with the name of the medication on it.
- The original container must have the **student's name** (first and last) on it.
- The container must state the name of the **prescribing physician.**
- The **dosage** must be specified.

Student Last Name First Name Middle Age Birthdate

Physician to Complete the Following:

PRESCRIPTION MEDICATIONS (If more space is needed, please attach a separate page with signatures)

Medication Name	Condition being treated	Method of Administration and Time to be Given	Dosage Amount and Frequency	Comments: Precautions/ side-effects to watch for	Discontinuation Date

For children with known bee sting or other severe allergic reactions:

Known Allergy: _____

What is to be given and when: _____

Physician's permission to carry Asthma inhaler: This student has been trained and is allowed to carry and self-administer an Asthma inhaler at school and on field trips—if yes, Asthma Action Plan required: Yes___

The student has an individualized health plan for:

___Asthma
___Diabetes
___Anaphylactic Response (Bee sting and/or Food Allergies)
___Seizures

Please continue on to page two on reverse

Over-the-counter medications are not used or kept at school except in special pre-authorized circumstances. If they are needed on field trips, including the sixth grade overnight Outdoor Education field trip, this form must be completed by the child's physician or we will NOT be able to administer the medication (even an aspirin or Tums) to your child.

OVER THE COUNTER MEDICATIONS

Approved Medication Name—Please list by classification (Generic versions may be used)	Dosage/Route if other than on packaging	Comments: Precautions, Side-Effects to watch for	Physician's Signature Indicating approval
Pain Relievers			
Cold Cough Medication			
Digestive Aids			
Creams and Ointments			
Allergy Relief			
Other Approved Medications (If applicable)			

The information on this form is current and is in effect until: (Date) _____

_____

Physician Name Address Phone

_____

Signature License Number Date signed by physician

Parent/Guardian Completes the Following: I hereby give permission for the designated school personnel to administer the above medication(s) to my child as prescribed by his/her physician during school hours or while on a school sponsored trip or other activity off-campus. I agree to hold the district, its officers, employees, or agents harmless from all liability, suits, claims, of whatever nature or kind, which may arise out of these arrangements.

Signature of Parent/Guardian Contact Phone Date

Please fax to school: K-3rd grade: Yulupa School Fax 707 544-0360; 4th-6th Strawberry School 707 526-0906

(8/19/13)