Loomis Union School District

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

SCHOOL MEDICATION FORM

Fax Information to:

☐ *Franklin Elementary* Phone: (916) 652-1818 Fax: (916) 652-1821	☐ *Loomis Grammar* Phone: (916) 652-1824 Fax: (916) 652-1826	☐ *Placer Elementary* Phone: (916) 652-1830 Fax: (916) 652-1832	☐ *H. C. Powers Elementary* Phone: (916) 652-2635 Fax: (916) 652-2679
☐ *Penryn Elementary* Phone: (916) 663-3993 Fax: (916) 663-2127	☐ *Ophir Elementary* Phone: (530) 855-3495 Fax: (530) 823-9101	☐ *Loomis Basin Charter* Phone: (916) 652-2642 Fax: (916) 652-1822	☐ *Loomis Union School District Office* Phone: (916) 652-1800 Fax: (916) 652-1809

Student Name _____ **School** _____ **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 (Optional): _____

Allergies (Medication/Other substances): _____

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

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:** _____