

# BATTLE BORN YOUTH CHALLENGE ACADEMY



Revised January, 2025

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## MEDICAL APPLICATION

*(Part Two)*

*Complete History Survey and see your Medical Care Provider with these forms.*

*The Youth & Medical applications must be submitted in their entirety before consideration can be given for acceptance.*

**Battle Born Youth Challenge Academy**

**PO Box 700**

**Carlin, NV. 89822**

<http://www.bbyca.org>

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The Battle Born Youth Challenge Academy, in accordance with Nevada State Law, does not discriminate based on age, sex, sexual orientation, gender, expression or gender identity, marital status, race, creed, color, national origin or disability.

# Battle Born Youth ChalleNGe Academy Medical Application

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## Dear Health Care Provider:

Please complete this Physical Form for admission to the Battle Born Youth ChalleNGe Program (BBYCA). BBYCA is a volunteer program for youth 16-18 years of age, who are at-risk for dropping out of school or have already dropped out, located in Carlin, Nevada. The goal of our Program is to give youth a second chance to become responsible and productive citizens.

This Program consists of a 5-1/2 month residential stay in Carlin, Nevada. The Program training can be physically demanding and potentially hazardous. Physical training could include such physically strenuous activities as:

1. A daily run of two (2) or more miles over various terrains.
2. Daily vigorous physical exercises.

The Program is structured with a quasi-military model, promoting personal time management, accountability, and promoting positive and negative consequences for behavior. Cadets will be expected to comply with rules and regulations.

Mental and emotional demands of the Program include separation from family and loved ones, military-style discipline, military ceremonial drill for prolonged periods of time, marching and physical training. Cadets will live in close communal barracks with up to 50 other Cadets and must be able to cope with the inherent stress levels of barracks life.

We are staffed medically by one nurse (RN) and military medical personnel who will see Cadets for minor injuries and illnesses. **We do not have a medical provider on staff, therefore, all medications will need to be maintained by the original prescriber throughout the youth's stay at BBYCA. Please provide or arrange for refills for the entire 6-months of his/her stay.** If this is not possible, please ensure the prescription is current, valid, and may be filled at our pharmacy.

This examination is for determining fitness to engage in strenuous activities and the *highly structured, stressful environment, as outlined above*. In most cases, the exam must be performed within twelve (12) months of the first day of the class start date. A shorter time interval may be required in some cases.

Any questions you have concerning this examination or your patient's ability to participate can be answered by contacting our medical department at **775-431-7062**. **All participants must have a physical, up-to-date immunizations, dental exam, and vision exam completed prior to acceptance.**

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**Medical Department:**

**775-431-7062**



# Battle Born Youth Challenge Academy Medical Application

**PURPOSE:** The following information must be filled-in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

## BBYCA MED Form A2 - MEDICAL EXAMINATION

**APPLICANT'S NAME:** \_\_\_\_\_  
Last First Middle

**Gender:**  Male  Female **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **P:** \_\_\_\_\_ **R:** \_\_\_\_\_ **B/P:** \_\_\_\_\_

Has the applicant had any history, including hospitalizations/diagnosis of the following:

Yes	No		Yes	No	
		ADD			Bi Polar Disorder
		ADHD			Autism Spectrum Disorder
		Anxiety			Behavioral Hospitalization
		Depression			Drug/Substance Abuse Hospitalization
		OCD			Mental Health Hospitalization
		ODD			Suicidal Ideation
		Eating Disorder			Suicide Attempt
		Personality Disorder			Violent Outbursts
		Allergies			Dietary restrictions

Please Describe any Yes answers: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PHYSICIAN SIGNATURE:**

\_\_\_\_\_  
 Physician Printed Name & Signature Physician Phone # Date of Evaluation

\_\_\_\_\_  
 Physician Address Physician Fax # Physician License Number and State

# Battle Born Youth ChalleNGe Academy Medical Application

## BBVCA MED Form B - MEDICATION AUTHORIZATION

**APPLICANT'S NAME:** \_\_\_\_\_  
Last First Middle

**MEDICATION AUTHORIZATION:**

I give permission to the Academy Nurse and to those persons whom he/she has in-serviced to administer the medication(s) listed below. I give permission to the Academy Nurse as warranted, with the undersigned physician, regarding my youth's medications. I hereby agree to indemnify and hold forever harmless the Battle Born Youth ChalleNGe Academy and their respective officials, agents, servants, and employees, against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor, for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state, as against such claim for reimbursement or indemnity.

***MEDICATIONS SHOULD BE MAINTAINED BY THE ORIGINAL PRESCRIBER THROUGHOUT THE YOUTH'S STAY AT BBYCA. PLEASE PROVIDE REFILLS FOR THE ENTIRE SIX (6) MONTHS OF THEIR STAY.***

**SIGNATURES:**

Youth Applicant Signature	____/____/____ Date
Parent/ Legal Guardian Printed Name & Signature	____/____/____ Date

**PHYSICIAN'S ORDER** (to be completed by a LHP):

Please list all prescription medication. All medications to be given by nebulizer must be provided in individual doses.

Medical Condition	Medication Name	Strength	Dosage	Route	Physician Signature

# Battle Born Youth Challenge Academy Medical Application

## ELKO COUNTY SCHOOL DISTRICT

### IMMUNIZATIONS REQUIRED FOR SCHOOL ENROLLMENT

VACCINE	MINIMUM NUMBERER OF DOSES
<b>Diphtheria, Tetanus, Pertussis (DTaP, Td)</b>	4-5 Doses Dose 5 is not necessary if Dose 4 was received after the fourth birthday 11 Students aged 7-18 may require 3-4 doses; refer to Catch-up schedule for number of doses and intervals.
<b>Diphtheria, Tetanus, Pertussis (Tdap)</b>	1 Dose One dose of Tdap is required prior to 7th grade entry. All new students entering 7-12 grades must have one dose of Tdap
<b>Hepatitis A (Hep A)</b>	2 Doses Must be given after the 1st birthday with at least 6 months between doses
<b>Hepatitis B (Hep B)</b>	3 Doses Must be at least 24 weeks (6 months) of age at time of dose 3
<b>Measles, Mumps, Rubella (MMR)</b>	2 Doses Must be given after the 1st birthday with 4 weeks between doses
<b>Meningitis (MCV4)</b>	1 Dose One dose of MCV4 is required prior to 7th grade entry. All new students entering 7-12 grades must have one dose of MCV4
<b>Polio (IPV)</b>	3 -4 Doses The final dose of IPV series must be administered after the 4th birthday.
<b>Varicella (VZV)</b>	2 Doses, or Health Care Provider/Laboratory Verification

*\*Children who are 3 years old and are enrolling in school must be up-to-date with their immunizations. Please note that the final dose in the series (ie: Dtap, Polio, **MMR**, Varicel/a) will be due at age 4. Additionally, applicant must have been tested for tuberculosis in the last 4-years and present a negative test result when applying for the BBYCA. If the test results were positive, applicant must also present a current chest **x-ray**.*

## BBVCA MED Form C - SELF REPORT MEDICAL HISTORY

**PURPOSE:** The following information must be filled-in and signed, in order for the youth to participate in BBYCA. Understandably, youth will need to be able to withstand the physical and emotional stressors. These questions are designed to determine if the youth has developed any condition which would make it hazardous to participate in BBYCA academic/ athletic program. "Yes" answers are not necessarily disqualifiers. Dishonesty or non-disclosure of medical history are disqualifiers.

**Applicant's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last First Middle

**Parent/ Legal Guardian:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Physician Phone#:** \_\_\_\_\_

**Do you have or have you ever had?**      **No**      **Yes**      **If yes, Explain:**

	No	Yes	
Asthma			
Sinusitis or Hay Fever			
Epilepsy or seizures			
Wear corrective lenses			
Lack of vision in either eye			
Hearing loss			
Food allergies			
Medication allergies			
Nose Bleeds			
Shortness of Breath			
Palpation or Pounding Heart			
High or Low Blood Pressure			
Eating disorder			
Frequent sore throats			
Recurrent ear infections			
Frequent or severe headaches			
Dizziness or fainting spells			
Head injury			
Nerve injury			
Tonsils removed			
Jaundice or hepatitis			
Broken bones			
Skin disease			
Organ loss			
Hernia			
Periods of unconsciousness			
Recent gain/ loss in weight			
Wear a brace or back support			
Swollen or painful joints			
Arthritis, rheumatism, or bursitis			
Frequent or painful urination			

# Battle Born Youth ChalleNGe Academy Medical Application

Do you Have or have you ever had?	No	Yes	If yes, Explain:
Recurrent Back pain or any back injury			
Trick or locked Knee			
Bed wetting since age 12			
Household contact with anyone with tuberculosis			
Tuberculosis or positive TB test			
Have you ever been sexually active			
STC/Syphilis/Gonorrhea, etc.			
Diagnosed with a learning disability			
Used illegal substance/Use tobacco			
Sleep Walking			
Been a patient in any type of hospital			
Had or been advised to have any operations?			
Illness or injury other than those noted			
Diabetes or Hypoglycemia*			
Heart Trouble			
Pain or pressure in chest			
Bone, joint, or other deformity*			
Suicide attempt or plan			
Treated for a mental health condition			
Chronic depression			

**Females Only:**

*Questions with an \* require clearance from a healthcare provider.*

Treated for a female disorder			
Change in menstrual pattern			
Do you take any Birth Control			
Date of last Menstrual Period: ___/___/___			
Wear a brace or back support			
Swollen or painful joints			
Arthritis, rheumatism, or bursitis			
Frequent or painful urination			

*Please ensure you have not left any question unanswered. (Circle those questions you don't know the answers to, in order to indicate that you **have** read them). Include explanations on the following page for all those questions marked, "Yes." Explanations should include any of the following format that is applicable: "Date from - Date to, explanation or cause of illness or injury, treatment, or medication received/completed, outcome/result, etc.*

\_\_\_\_\_  
Youth Applicant Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Printed Name & Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# Battle Born Youth ChalleNGe Academy Medical Application

## BBYCA MED Form D-MEDICATION HISTORY

**APPLICANT'S NAME:** \_\_\_\_\_  
Last First Middle

Are you currently using any over-the-counter medications?  Yes  No

Are you currently using any prescribed medications?  Yes  No

If yes, list all medications -dose and time taken: \_\_\_\_\_

Medicine	Dose	Time	How long have you been taking it?

Have you stopped taking prescription medications within the last 3 months?  Yes  No

If yes, list medications, and reasons for originally taking and reasons for discontinuing: \_\_\_\_\_

Medicine	Reason for Medication	Why did you stop?

Are you allergic to any medications, foods, or other agents such as bee stings, ragweed, etc.?  Yes or  No

If yes, explain: \_\_\_\_\_

Do you have a current prescription for an Epi-pen?  Yes or  No

Do you have a current prescription for an inhaler?  Yes or  No

**SIGNATURES:**

I certify that I have reviewed the foregoing information, supplied by me, and that it is true and complete.

\_\_\_\_\_  
 Youth Applicant Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/Legal Guardian Printed Name & Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

# Battle Born Youth ChalleNGe Academy Medical Application

## BBVCA MED Form E-DENTAL HEALTH STATEMENT

**PURPOSE:** This patient is an Applicant for the Battle Born Youth ChalleNGe Academy (BBYCA). A dental examination is required by BBYCA to identify any required or anticipated dental work. **This is a mandatory requirement for all Applicants.** Our desire is that Cadets are able to participate in our Program, free from pain and discomfort caused by needed dental work. **Examinations can be no older than one (1) year from Program class start date.** Please complete the information below. This will facilitate this requirement.

Applicant's Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_  
Last First Middle

\_\_\_\_\_ By initialing, I certify that I have examined this youth and he/she has no apparent dental problems or concerns at this time.

Please indicate any dental or orthodontic treatments, if applicable:

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**Wisdom teeth will not be removed during the 5-1/2 month Residential phase of the program. If surgery is indicated, it needs to be completed at least two-weeks prior to the scheduled registration date. Sites must be completely healed and a release should be obtained from the dentist.**

Cadets who wear braces should have adjustments made during scheduled break. Any appointments for orthodontic work will not be accommodated during the residential phase.

### **SIGNATURES:**

\_\_\_\_\_  
Dental Care Provider Printed Name

\_\_\_\_\_  
Dental Care Provider Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Mailing Address City State Zip Code

\_\_\_\_\_  
Phone

# Battle Born Youth Challenge Academy Medical Application

## BBYCA MED Form F - CONSENT FOR MEDICAL CARE

APPLICANT'S NAME: \_\_\_\_\_  
Last First Middle

Social Security Number: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Mailing Address City State Zip Code Phone Number

**\*This section is MANDATORY and must be filled out COMPLETELY\***

### **EMERGENCY CONTACT:**

Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_

### **RESPONSIBLE PARTY (Person who is responsible for medical co-pays and outstanding balances):**

Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street City State Zip Code

Email address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### **MEDICAL INSURANCE INFORMATION (Include a copy of your insurance card and/or Medicaid card - front & back):**

Medical Insurance Company: \_\_\_\_\_ .Medicaid or Group#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ Ins. Phone#: \_\_\_\_\_

### **SIGNATURES:**

I hereby grant permission to BBYCA to provide medical care for my son/daughter. If my son/daughter needs emergency medical/dental attention due to an accident or injury, I hereby authorize the attending medical/dental personnel at the Emergency Facility to provide whatever treatment is necessary, to include but not limited to x-rays, anesthesia, diagnostic procedures, medical procedures, dental procedures, and/or interventions. In the event of an emergency illness or injury, I understand that reasonable effort will be made to contact me. Reasonable effort means that I may not be contacted first, but I will be contacted as soon as possible by the staff from BBYCA. I understand that BBYCA has full-time medical professionals. I grant permission for any of the Medical Staff and Cadre Team Leader in-charge to dispense medication to my son/daughter. This medication may be a prescription, which has been prescribed directly to my son/daughter by a physician, or it may be over-the-counter medication, as deemed necessary by BBYCA.

It is further understood that BBYCA carries medical insurance for accidental injuries only. Medical care outside the scope of BBYCA Staff will be the financial responsibility of the parent/ legal guardian. The Medical Staff will determine the need for my son/daughter to be seen by a physician, if necessary.

\_\_\_\_\_  
Youth Applicant Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Legal Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# Battle Born Youth ChalleNGe Academy Medical Application

## BBYCA MED Form G-AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER MEDS

**PURPOSE:** Both the parent/guardian and Applicant must read and sign this form, indicating their agreement and acceptance of the terms and conditions outlined below.

APPLICANT'S NAME:

\_\_\_\_\_

Last

\_\_\_\_\_

First

\_\_\_\_\_

Middle

### LIST OF OVER-THE-COUNTER MEDICATIONS THAT MAY BE USED:

#### Health Complaint

Allergies  
Athlete's Foot  
Bee Sting  
Cold, cough, sore throat  
Constipation  
Cramps  
Cuts, scrapes, lacerations  
Diarrhea  
Ear care  
Eye Irritation  
Ingrown toenail  
Insomnia  
Irritated skin, bug bites, chapped lips  
Lice treatment  
Minor burns, sunburn  
Mouth.pain  
Pain, fever, headache  
Upset stomach, heartburn  
Lactose Intolerant

#### Examples of Medication Used

Benadryl, Claritin, Allegra, Zyrtec  
Lotrimin, Anti-fungal creams  
Hydrocortisone cream, Benadryl  
Mucinex, Coldonyl, Sudonyl, Delsem, chloraseptic spray  
Milk of Magnesia, Colace, MiraLAX  
Ibuprofen, Tylenol, Midol  
Hydrogen Peroxide, Bacitracin, Triple antibiotic ointment  
Imodium, Bismuth subsalicylate, Alkalak  
Debrox, Hydrogen Peroxide  
Artificial tears, Visine  
Epsom salt soak  
Melatonin  
Aloe, Hydrocortisone cream, Carmex, Vaseline  
RID lice killing shampoo  
Aloe, sunscreen lotion  
Ambesol, orasol gel, dental wax  
Tylenol, Ibuprofen, Naproxen  
TUMS Antacid, Bismuth subsalicylate, Pepcid  
Lactase Enzyme Chewable tablets

### SIGNATURES:

I authorize the BBYCA Staff to give certain over-the-counter medications (per label instructions) for the treatment of minor injuries and illnesses (listed above). Before giving medications, the Nurse checks medical history, allergies, and any other medications your youth is taking, to make sure there is no conflict.

\_\_\_\_\_  
Youth Applicant Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Legal Guardian Printed Name & Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

# Battle Born Youth ChalleNGe Academy Medical Application

**PURPOSE:** This form outlines the medical conditions that might prevent entrance or continued enrollment into BBYCA. It explains the policies and procedures that govern how medications and medical services are provided to the Applicant.

## BBYCA MED Form H-UNDERSTANDING OF LIMITED MEDICAL SERVICES

**APPLICANT'S NAME:** \_\_\_\_\_

Last

First

Middle

### OVERVIEW:

The Battle Born Youth ChalleNGe Academy (BBYCA) has very limited medical services available to the Applicant. BBYCA has two full-time nurses that are available for minor illnesses and injuries. We are unable to provide and do not have the resources to transport youth to any "on-going" treatment or care. We are unable to accept Applicants who will require on-going psychiatric, medical or dental care. Parent(s)/legal guardian(s) are to take care of all medical, dental, and vision matters that will prevent Program participation prior to registration. All medical conditions must be disclosed at time of application. If it is learned after the Applicant arrives at BBYCA that serious medical conditions exist, the youth will be dismissed from the Program and sent home. BBYCA will not accept responsibility, financial for personal liability, or risk for previous medical, physical, or mental histories that limit participation in the Program. Applicants must have a physical examination completed by a licensed medical provider within twelve months from the start date of the class for which they are applying. All injuries and dental/medical/vision conditions must be resolved, and the Applicant free from additional required care, prior to entrance into the Program.

The following conditions will prevent entrance into BBYCA:

- Extensive use of multiple medications necessary to treat multiple conditions on a daily basis.
- Current or previous injuries/surgeries that prevent full participation in all BBYCA activities.
- Dental services: braces adjustments, broken teeth, cavities, abscess and mouth disorders that impact/prevent the ability of the Applicant to participate without on-site care or assistance.
- Conditions or medications that adversely react or have side effects impacted by the high intensity physical activity and seasonal weather conditions that compromise the safety, health, and welfare of the youth. Medications/conditions that may react adversely to extreme summer heat and winter cold.
- Historic or current conditions requiring medical, psychological or psychotic intervention for suicide treatment, manic depression, anxiety, etc. Mental health services are not available from BBYCA.
- Extensive dietary restrictions medically required by a medical physician.

BBYCA medications/medical care policy:

- All required prescription medications must be disclosed in advance during the application process.
- All potential side effects and limitations of required medications must be disclosed at time of application.
- A medical release, approval and signature must be provided by the doctor in advance stating: Applicant can safely participate in extreme hot and cold conditions, while consuming required prescription/medication(s).
- Parents/guardians are entirely responsible for all prescription medications and re-fills during the Program.
- Parents/guardians are responsible for all required medical/dental/psychological care before, during, and after participation in BBYCA.
- Injuries/physical/medical changes or new medications, required by the Applicant after the initial physical examination, must be disclosed in writing prior to entry into BBYCA for purposes of review, safety, health, and welfare.
- Cadets with psychiatric, dental or medical needs that require ongoing "emergency" care off-site and time away from the Program for five (5) days, or that prevent participation will be dismissed and sent home.
- Medical/dental/vision care that does not hinder participation is to occur during BBYCA scheduled break.

### SIGNATURES:

I understand and agree that I am responsible for all medical/dental/mental health care of my youth during, before and after participation in BBYCA. By my signature below, I acknowledge that I have read and understand the above medical information.

\_\_\_\_\_  
Youth Applicant Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Legal Guardian Printed Name & Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Over-the-Counter Medicines in Stock

As a 24/7 youth facility, the Elko County School System mandates that Battle Born Youth Challenge Academy administers only prescribed and over the counter (OTC) medications signed by both the parent/guardian and the healthcare provider. This policy ensures the safe administration of medications.

Below is a list of medications stocked at the school. Please check all the medications you wish your child to receive and have your physician sign the form. For any questions, please contact the BBYCA nurses' office at 775-781-2465 or 775-684-9272. Thank you.

### ALLERGY

- Diphenhydramine HCl 25mg, 1-2 capsules PO every 4-6 hours PRN symptoms due to hay fever or upper respiratory allergies. (Benadryl)
- Loratadine 10 mg, 1 tablet PO daily PRN to relieve symptoms of hay fever or other respiratory allergies. (Claritin)
- Miconazole nitrate 2% One spray topically over infected area twice a day PRN athletes' foot.
- Tolnaftate 1% 1 spray topically over infected area twice a day PRN jock itch
- Miconazole Nitrate 2% Powder. Apply over the affected area topically twice a day in the morning and night PRN athletes' foot, ring worm or jock itch. Use 4 weeks maximum for athletes' foot and ringworm. Use for a maximum of two weeks for jock itch.
- Tolnaftate Cream 1%. Apply over the affected area topically once a PRN athletes' foot, ring worm or jock itch. Use 4 weeks maximum for athletes' foot and ringworm. Use for a maximum of two weeks for jock
- Hydrocortisone cream 1% apply to affected area topically no more than 3-4 times daily PRN itching, rashes, and minor skin irritations
- Benadryl Cream 2% Apply to affected area topically no more than 3-4 times daily PRN rashes, itching, and minor skin irritations.
- Calamine lotion is applied topically PRN as needed to dry the oozing from poison oak, sumac, and ivy. Do not use it for more than 7 days.
- Sting Relief Pads apply to affected area up to 4 times daily PRN insect stings

### Cold/Flu

- Mucinex 1 Tablet every 4 hours by mouth PRN cough and thick mucus.
- Multi Symptom Cold and Cough medicine, 2 caplets every 4 hours by mouth PRN cold and flu symptoms.
- Sudafed PE, 1 tablet every 4 hours by mouth PRN sinus congestion
- Mentholatum apply to affected area no more than 4 times daily PRN chest ache from colds
- Chloraseptic Lozenges 1 lozenge by mouth every 2 hours PRN sore throat
- Cough Drop 1 lozenge by mouth every 2 hours PRN cough

## Pain/Temps

- Ibuprofen 200mg 1-2 tablets PO every 8 hours PRN mild pain or T>38.5 C
- Tylenol 325mg 1-2 tablets PO every 4-6 hours PRN mild pain or T> 38.5 C
- Aleve 220 mg 1 tablet PO every 8 hours prn mild pain
- Midol 2 caplets PO every 6 hours prn menstrual cramps (6 caplets max daily)
- BioFreeze Apply to sore muscle 3-4 times daily prn achiness
- PT-20 Sore muscle rub (Tiger Balm) Apply to sore muscle several times a day PRN achiness

## Digestive

- Loperamide HCL 2 mg. Give 2 caplets by mouth after the first loose stool then 1 caplet by mouth after each loose stool not to exceed 4 capsules in a 24-hour period PRN diarrhea
- Bismuth Subsalicylate 262mg, chew two tabs by mouth every ½ to 1 hour PRN diarrhea
- Mylanta 10-20 ml every 6-8 hours PRN nausea and gas not to exceed 60 ml per day
- Milk of Magnesia 2 to 4 tablespoons at bedtime by mouth PRN constipation
- Docusate Sodium 100mg 1-3 tablets daily by mouth PRN constipation
- Miralax one packet dissolved in 4-8 ounces of water and taken by mouth daily PRN constipation
- Dulcolax 5mg 1-3 tablets in a single dose PO PRN constipation
- Lactase 9000 FCC units take 1-2 caplet 30 minutes prior to ingesting milk PRN lactose intolerance

## Miscellaneous

- Earwax removal kit. Use 5 to 10 drops of Carbamide peroxide 6.5% to aer as directed prn wax removal
- Artificial Tears 1-2 drops to each affected eye prn eye redness, irritation, dryness
- Epsom salts, add to warm water and soak foot 10 minutes prn ingrown toenail.
- RID Shampoo lather in hair and let sit for 10 minutes before rinsing once a week PRN lice.
- Anbesol apply to site up to 4 times daily PRN oral pain
- Orasol gel 20% apply to site up to 4 times daily PRN oral pain
- Burn Gel Lidocaine 2% apply to affected area up to 4 times daily prn sunburn

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

The undersigned parent/guardian hereby requests BBYCA to assist and supervise the above-named student in taking the medication listed above during school. In addition, the parent/guardian gives permission to the School Nurse to exchange confidential information, relative to the medication noted above, with the undersigned physician/healthcare provider; and further agrees to hold the Elko County School District, the Board of Trustees of the District, and all agents of the District harmless from any liability for their participating in assisting and supervising the above named student in taking this medication.

Parent/Guardian \_\_\_\_\_ Print \_\_\_\_\_ Name \_\_\_\_\_  
Parent/Guardian Sign \_\_\_\_\_ Date \_\_\_\_\_

(Physician/Healthcare Provider, please print) \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_  
(Signature of Physician/Healthcare Provider) \_\_\_\_\_ Date \_\_\_\_\_



Store #: 08801

550 W Idaho St  
Phone: 775-738-7177

Elko, Nevada 89801  
Fax: 775-778-9384

## TRANSFER REQUEST

Pharmacy Requesting From: \_\_\_\_\_ Fax# \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Pharmacist on Duty: \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

RX #: \_\_\_\_\_ Drug: \_\_\_\_\_

Please include last fill dates, day supply and diagnosis code for any controls.  
Thank you- CVS Staff

## Link and instructions for the CVS Portal.

<http://www.cvs.com/retail-easy-account/create-account?page=/account/signup.jsp>

Setting up an account is quick and easy. Go to the Create an Account page, enter and confirm your email address (which becomes your User ID) and choose a password.

Please note: Passwords are case sensitive. They must be at least 7 characters long and include at least 1 letter and 1 number. They cannot include your User ID or the word "password". Only these special characters can be used: !@#\$%'"&\*()

You'll also be asked for information necessary to set up and protect your account.

As you set up your account, you can choose to:

- Receive offer-filled CVS.com® emails.
- Attach your ExtraCare® card to your account to earn rewards on online purchases and manage your Savings & Rewards online.
- Select Remember Me for a more personalized site experience.