



Medications Listed Below -  
Must have a form on file for each  
new medication(s) or renewal of  
an existing medication(s)

# MEDICATION SAFETY CLEARANCE FORM

Employee and Physician should complete IF currently taking  
or being prescribed prescription medications listed below.

## Employee's Section:

Printed Name: \_\_\_\_\_ Employee # \_\_\_\_\_

I understand that safety concerns related to my use of prescribed medications have been reported to the Shelby County Board of Education. In order to continue to perform my duties as a school bus driver, I must obtain clearance from my primary care/prescribing physician that it is safe for me to perform school bus driving duties while taking the medications I am currently prescribed. I attest that I have disclosed all prescribed medications to the physician completing this form and the information I have provided him/her is complete and correct.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Physician's Section:

*Please check which medication applies and initial in the box to the left-*  
Prescribed drugs that require physician clearance are:

|                                   |                        |                             |
|-----------------------------------|------------------------|-----------------------------|
| Doctor's<br>Initials<br><br>_____ | Amphetamines           | Methadone                   |
|                                   | Narcotics              | Buprenorphine               |
|                                   | Habit forming drugs    | Anti-seizure medication     |
|                                   | Tranxine, Ambien, Soma | Insulin (medical exemption) |

Name of Prescribed Medication(s): \_\_\_\_\_

As the attending/prescribing physician, I understand that the above-named patient is employed as a school bus driver for the Shelby County Board of Education and must have medical clearance that he/she can safely perform those duties while taking medications as prescribed. I have reviewed the medications prescribed for this patient and have made the following determination:

### (PHYSICIAN MUST INITIAL ONE OF THE FOLLOWING)

- \_\_\_\_\_ Employee may NOT perform bus driving duties while taking his/her prescribed medication(s)
- \_\_\_\_\_ Employee may perform bus driving duties while taking his/her prescribed medication(s)
- \_\_\_\_\_ Employee's medication(s) has been discontinued and employee is cleared to perform bus driving duties

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Phone Number