Just a reminder!

Dear Parent,

We have noted that you child has asthma or a reactive airway condition.

Please complete the following, and check off when completed:

1. _____ **Asthma History** form even if your child does not need medication at school (parent only).

2. _____ **Authorization for Administration of Medication** form (doctor and parent).

3. _____ If the doctor prescribes an inhaler, please request a spacer (Aerochamber) for school.

4. _____ For any medication prescribed, before you leave the pharmacy check that the *dose and time* for inhaler to be given *matches* the *dose and time* on the Medication Authorization form.

5. _____ Return these forms AND medication to the enrollment center by _____.

**********************IMPORTANT NOTE**********************

The completed forms AND prescribed medication must be received at the enrollment center before your child can attend preschool.

All medication must be in a pharmacy labeled box or in the original box/container (for over-the-counter medication).

Cordially,
Nurse Lisa and Lori
Sacramento City Unified School District
Child Development Department

SCUSD Early Learning & Care Department

Asthma History

(Parent/Guardian to complete and return to Nurse)

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Preschool: _____

When was your child's asthma first diagnosed? _____

_____

How often are your child's asthma episodes?

Daily _____ Weekly _____ Monthly _____ Seasonally _____ Other _____

How many times has your child been seen in the Emergency Room for asthma in the **past year**? _____

_____

How many times has your child been hospitalized for asthma since birth? _____

How would you rate the **severity** of your child's asthma?
(Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

☐ Exercise	☐ Indoor dust	☐ Respiratory Illness	☐ Wood smoke
☐ Cigarette smoke	☐ Pollen	☐ Strong chemicals	
☐ Carpet	☐ Outdoor dust	☐ Temperature change	

☐ Animal (Specify): _____

☐ Food (Specify): _____

☐ Other: _____

What triggers your child's asthma?

Please list the medication/s your child takes for asthma:

Medication Name	Route given (Nebulizer, Inhaler)	Amount	How Often

Will your child need rescue medication for asthma at school (such as Albuterol)? Yes/No

Parent Signature	Date/Phone	Nurse Signature	Date

H.F. 5
Rev. 10-09

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Community, Health and Education Support Services Division
Health Services Office

Doctor

AUTHORIZATION FOR ADMINSTRATION OF MEDICATION BY SCHOOL PERSONNEL

PLEASE NOTE: this form must be completed each school year or more frequently, if necessary.

I. Basic Legal Provision - California Education Code, Section 49423

Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the name of the medication, method of administration, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

Designated school personnel may administer medication to pupils upon written request of the pupil's parent/guardian and physician **only** when the medication is in the original container.

II. Physician Instructions

Student _____ Age _____ Birth date _____

School _____ Grade _____

TO PHYSICIAN: Please note: Whenever possible, please prescribe medication that can be given outside of the school day. If medication must be administered during school hours, please complete the information below:

MEDICATION(S)	DOSAGE	ROUTE OF ADMINSTRATION	APPROXIMATE TIME OF DAY

Diagnosis or indication for medication _____

Length of time to be taken _____

Precautions or additional instructions _____

a. For emergency medication, is the student capable of self-administering the necessary treatment/medication?
☐ Yes ☐ No

b. Will the student need to carry this medication on his/her person? ☐ Yes ☐ No

c. Will the student need to self-administer this medication? ☐ Yes ☐ No

Please note obvious side effects to this particular medication _____

_____

Signature of Physician _____ Address _____

Print/Type Physician's Name_____ Phone _____ Date _____

III. Parent Request

Parent

Please check one of these boxes.

☑ I/We the undersigned, who am/are the parent(s) of _____ request that medicine be administered to said child by a designated member of the school staff, in accordance with the instructions outlined here and signed by our physician. The medication is to be given at ___*prescribed time*____ (time) with the following special instructions: __*as ordered by doctor.*_____.

☐ As indicated here in our physician's statement, our child, _____, will self-administer his/her own medication when required and we are not requesting school personnel to assist in the administration of our child's medication. Our child will need to self-administer his/her medication at school because he/she suffers from _____ (state nature of illness). Our child will need to take his/her medication _____ (number of times per day) with the following special instructions: _____
_____
_____
_____

I/We hereby release, discharge and hold harmless Sacramento City Unified School District and its officers, agents and employees for any and all claims of civil liability arising out of an act or omission that causes our child to suffer an adverse reaction as a result of his/her self-administering medication.

We understand that the major responsibility for a child taking medication rests with the child and his/her parents, and that we are required to personally bring the medication to school for students kindergarten through 8th grade. We understand that students in grades 9 through 12 may bring their own medication to the school office.

_____ _____ _____ _____

Parent/Guardian Signature | Date | Home Phone | Work Phone

_____

Address

Emergency contact: _____ Phone: _____