

Just a reminder!

March, 2018

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 <u>dose and time</u> for inhaler to be given <u>matches</u> the <u>dose</u> <u>and time</u> on the Medication Authorization form.

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

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, Lorí and Víctoría* Sacramento City Unified School District Child Development Department



Asthma History Form

Student Name:			Date of Birth:			
Parent(s)/Guardian(s):						
When your child's How frequent are	asthma was	first diagnose	ed?			
Daily We	eks	Months	Seasona	ally (Other	
How many times h asthma in the past	-		n the Emerger	-	spitalized for	
How would you rate (Not Severe) 1 2 What triggers your	3 4 5 6	7891				
Exercise		/Illness	Pollens		emperature change	
Cigarette smoke	🗆 Indoo	or dust	Outdoor	dust 🗆 V	Vood smoke	
CarpetAnimal (Specify)		g/chemicals				
 Food (Specify) Other 						
What medication/s						
Medication Name		Route given (Nebulizer,		Amount	How Often	

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. <u>Basic Legal Provision</u> - 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. <u>Physician Instructions</u>

Student	Age E	Birth date
School		Grade

<u>TO PHYSICIAN: Please note:</u> 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? \Box Yes \Box No
- c. Will the student need to self-administer this medication? \Box Yes \Box No

Please note obvious side effects to this particular medication

 Signature of Physician
 Address

Print/Type Physician's Name
 Phone

Date

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III. Parent Request

Parent

Please check <u>one</u> of these boxes.

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:	