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

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Child Development Department

Parent

Asthma History Form

Student Name: ______________________ Date of Birth: __________
Parent(s)/Guardian(s): ______________________ Preschool: __________

When your child's asthma was first diagnosed? ______________________
How frequent are your child's asthma attacks?

Daily ______ Weeks ______ Months ______ Seasonally ______ Other ______

How many times has your child been seen in the Emergency Room/Hospitalized for asthma in the past year? ______________________

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

What triggers your child's asthma?

- ☐ Exercise
- ☐ Colds/Illness
- ☐ Pollens
- ☐ Temperature change
- ☐ Cigarette smoke
- ☐ Indoor dust
- ☐ Outdoor dust
- ☐ Wood smoke
- ☐ Carpet
- ☐ Strong/chemicals
- ☐ Animal (Specify) ______________________
- ☐ Food (Specify) ______________________
- ☐ Other ______________________

What medication/s does your child take for asthma?

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

______________________ ______________________
Parent Signature Date/Phone Nurse Signature Date

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: ________________