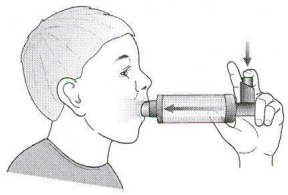

ASTHMA MEDICATION FORM (One Medication Per Form)

Dear Parent/Guardian/Caregiver:

California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if the school district receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the Principal.**

Student Name: Last	First	Middle	Date of Birth (Month/Day/Year)

HEALTH CARE PROVIDER SECTION

Health Condition for which medication is prescribed: **ASTHMA**	Quick Relief Asthma Medication: __ALBUTEROL_____ Dose: **2 puffs (give 1 at a time, 1 minute apart), with spacer; inhale each puff and hold for 10 seconds**
How is medication to be given? Inhalation **WITH SPACER**	Frequency: **AS NEEDED, 4-6 hours apart**; if the inhaler is new or not used in the past 2 weeks, prime the device first, as described in the medication instructions. (To prime, spray the inhaler 3-4 times away from the face or follow medication package instructions.)
The medication is to be continued as above until: (please be as specific as possible about date)	If NOT on an as needed basis, about what time(s) does the quick relief medication need to be given at school? _____AM / PM
Any precautions that school personnel need to know? NONE Contraindications?	What are possible reactions/side effects? Rapid heart rate What should be done in the event of a reaction/side effect? If heartbeat is fast, rest for 10 mins. If Albuterol is not effective, repeat medication dose and seek medical care.

Check appropriate boxes below:

❒ I authorize this student to **self-administer** the above medication.

❒ I authorize designated school personnel to assist the student with taking the above medication.

Print Provider name, address & phone number	**Signature and NPI # of Health Care Provider**	**Date**

PARENT / GUARDIAN / CAREGIVER SECTION

Parent/Guardian/Caregiver Name			Home Language		Daytime Phone ( )
Address – Number and Street	Apt No.	City		Zip	Evening Phone ( )
Code					
School			Children's Center / ES / MS / HS		School Hours

Check appropriate boxes below:

❒ I permit my child to give himself/herself the above medication.

❒ I permit designated school personnel to assist my child with taking the above medication.

1. I agree to hold the San Francisco Unified School District (SFUSD) and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the SFUSD and its employees for any liability arising out of these arrangements.
3. I will notify the Principal of the school immediately if there is a change in my child's medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child's name and the health care provider's instructions.
5. I understand that this form automatically expires at the end of each school year.
6. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

Parent/Guardian/Caregiver Signature _____ Date_____