

PASADENA UNIFIED SCHOOL DISTRICT  
HEALTH PROGRAMS

**ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Address: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
School: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

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**THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER**

**TO THE HEALTH CARE PROVIDER:** Please complete and sign the center section of this form when prescription or non-prescription medication must be given during school hours. This form is required by Section 11753.1, California Education Code, to authorize school personnel to assist the students with the administration of medication.

Diagnosis or reason for medication: **Asthma**

	<u>Dose</u>	<u>Frequency</u>
Albuterol, Ventolin, Proventil MDI	_____	_____
Albuterol, Ventolin, Proventil Nebulizer	_____	_____
Other: _____	_____	_____

Any special instruction, precautions, or possible side effects:

How long will this medication be necessary?

Signature of Health Care Provider \_\_\_\_\_ Phone \_\_\_\_\_

Printed Name of Health Care Provider \_\_\_\_\_ Fax \_\_\_\_\_

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**THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN**

**TO THE PARENT OR GUARDIAN:** The medication must be delivered to the school in the original pharmacy container. Middle school and senior high school students may bring their medication to the health office. The parent or guardian must bring medication for grade-school aged students.

**PLEASE SIGN THE FOLLOWING STATEMENT:** I requested that the school assist my child, in taking the medication as directed above, and in accordance with the school policy.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

**DISTRITO ESCOLAR UNIFICADO DE PASADENA PROGRAMAS DE SALUD**

**ADMINISTRACIÓN DE MEDICAMENTO DURANTE LAS HORAS DE CLASES**

Nombre del Alumno \_\_\_\_\_ Fecha de nacimiento \_\_\_\_\_  
Domicilio \_\_\_\_\_ No. de teléfono del hogar \_\_\_\_\_  
Escuela \_\_\_\_\_ Grado \_\_\_\_\_ Maestro/a \_\_\_\_\_

**ESTA SECCIÓN ES PARA QUE LA COMPLETE EL PROVEEDOR DE CUIDADO DE SALUD**

**TO THE HEALTH CARE PROVIDER:** Please complete and sign the center section of this form when prescription or non-prescription medication must be given during school hours. This form is required by Section 11753.1, California Education Code, to authorize school personnel to assist the students with the administration of medication.

Diagnosis or reason for medication: **Asthma**

	<u>Dose</u>	<u>Frequency</u>
Albuterol, Ventolin, Proventil MDI	_____	_____
Albuterol, Ventolin, Proventil Nebulizer	_____	_____
Other: _____	_____	_____

Any special instruction, precautions, or possible side effects:

How long will this medication be necessary?

Signature of Health Care Provider \_\_\_\_\_ Phone \_\_\_\_\_

Printed Name of Health Care Provider \_\_\_\_\_ Fax \_\_\_\_\_

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**ESTA SECCIÓN ES PARA QUE LA COMPLETE EL PADRE O TUTOR**

**AL PADRE O TUTOR:** El medicamento debe ser entregado a la escuela en el envase original de la botica. Los estudiantes de las escuelas intermedias y secundarias pueden traer su medicamento a la oficina de salud. El padre o tutor de los alumnos de la escuela elemental deben de llevar el medicamento a la escuela.

**POR FAVOR FIRMEN LA SIGUIENTE DECLARACIÓN:** Pido que la escuela ayude a mi hijo/a que se tome la medicina como es indicado arriba y de acuerdo con las reglas de la escuela.

Firma del Padre o Tutor \_\_\_\_\_ Fecha \_\_\_\_\_