PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS/ FOR INHALERS TO BE CARRIED BY STUDENTS

Name of Pupil _____ Birthdate _____

Address _____ Home Phone _____

_____ School _____

TO THE HEALTH CARE PROVIDER:

Your patient has advised the school staff that he/she may carry and use an inhaler during school hours.

Please complete and sign this form if an inhaler prescribed for a school age child may be used during school hours. This form is required by California Education Code, Section 11753.1, to authorize school personnel to permit the child to carry and use an inhaler at his/her own discretion.

Date _____

Diagnosis or reason for medication:

Inhaler prescribed, dosage, time to be taken:

Any special instruction, precautions, or possible side effects:

How long will this medication be necessary?

Signature of Provider _____ Phone _____

Print Name of Provider _____

TO THE PARENT OR GUARDIAN: The inhaler may be carried by the student and used as prescribed after this form has been filed with your school health office.

PLEASE SIGN THE FOLLOWING STATEMENT: I request that the school permit my child to carry and use an inhaler during school hours as prescribed by his/her physician.

Signature of parent or guardian _____ Date _____

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

ADMINISTRACION DE MEDICAMIENTO DURANTE LAS HORAS DE CLASES/ ESTUDIANTES QUE DEBEN LLEVAR SU INHALADOR CONSIGO

Nombre del Alumno _____ Fecha de Nacimiento _____

Domicilio _____ Tel del Hogar _____

_____ Escuela _____

TO THE HEALTH CARE PROVIDER:

Your patient has advised the school staff that he/she may carry and use an inhaler during school hours.

Please complete and sign this form if medication prescribed for a school age child must be given during school hours. This form is required by Section 11753.1, California Education Code, to authorize school personnel to assist the pupil with the medication.

Date _____

Diagnosis or reason for medication:

Inhaler prescribed, dosage, time to be taken:

Any special instruction, precautions, or possible side effects:

How long will this medication be necessary?

Signature of Provider _____ Phone _____

Print Name of Provider _____

Address _____

AL PADRE O TUTOR: El estudiante puede llevar el inhalador consigo y usarlo según instrucciones de su médico una vez que esta forma sea devuelta a la oficina de la escuela.

POR FAVOR FIRMEN LA SIGUIENTE DECLARACION: Solicito que la escuela permita a mi hijo/a llevar su inhalador consigo y usarlo según las instrucciones de su médico.

Firma del Padre o Tutor _____ Fecha _____