NEWARK UNIFIED SCHOOL DISTRICT

5715 Musick Avenue, Newark, CA 94560 | (510) 818-4103

Inhaler/Medication for Child to Carry and Self Administer

Date: _____

_____ (student) has been instructed in the proper use of the inhaler/medication _____. The child's well-being is in jeopardy unless the inhaler/medication is carried on his/her person; therefore, we request that he/she be permitted to carry the inhaler/medication. He/she understands the purpose, appropriate method, and frequency of use of this inhaler/medication.

Physician's Signature **Date**

Physician's Name: _____

Address: _____

Phone: ( ) _____

I permit my child to carry the above listed inhaler/medication as ordered by his/her physician. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature **Date**

THIS FORM MUST BE COMPLETED IN ADDITION TO THE ROUTINE DISTRICT MEDICATION AUTHORIZATION FORM.

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lnhalador/Medicamento para que un Nino(a) Puede Cargar y Administrar a Si Mismo

Fecha: _____

_____ (estudiante) ha sido instruido en el uso proprio de medicarnento/inhalador. El bien estar del nino(a) esta en peligro se el nino (a) no carga su medicina en su persona; asi es que pedimos se permiso para que el/ella pueda cargar su medicarnento. El/ella entiende el proposito, metodo apropriado y frequencia del uso de este medicarnento.

_____

Firma del Doctor **Fecha**

Nombre del Doctor: _____

Direccion: _____

Telefono: ( ) _____

Yo permit que me nino (a) lleve este medicarnento ordenado por su doctor. Yo comprendo que el/ella no debe compartir su meicarnento cono otros estudiantes pues esto resultaria en accion desciplinaria.

Firma de Padres/Guardianes **Fecha**

ESTA FORMA SE DEBE COMPLETAR Y TAMBIEN LA FORMA DE AUTORIAZACCION DE MEDICAMENTO DEL DISTRITO.