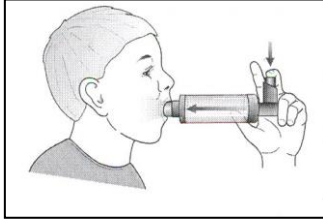


# San Francisco Unified School District



## ASTHMA MEDICATION FORM (One Medication Per Form)

親愛的家長/監護人/看顧人：

加州教育法令第 49423 條規定，

學生如需在上課日服用醫生處方或非醫生處方藥物，可由學校人員協助，但只

在校區收到醫護服務提供者及學生家長/監護人/看顧人的具體書面說明後，方予進行。請填妥本表格各部分，並交回校長。

**P l e a s e   p r i n t   l e g i b l y   i n   a l l   s e c t i o n s**

Student Name: Last	First	Middle	Date of Birth (Month/Day/Year)
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### HEALTH CARE PROVIDER SECTION

Health Condition for which medication is prescribed:  <p style="text-align: center; font-weight: bold; font-size: 1.2em;">ASTHMA</p>	Quick Relief Asthma Medication: _____ Dose: <b>2 puffs (give 1 at a time, 1 minute apart), with spacer; inhale each puff and hold for 10 seconds</b> Frequency: <b>AS NEEDED, 4-6 hours apart</b> ; 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.)	
How is medication to be given? Inhalation	If NOT on an as needed basis, about what time(s) does the quick relief medication need to be given at school?  <p style="text-align: right;">_____ AM / PM</p>	
The medication is to be continued as above until: (please be as specific as possible about date)	What are possible reactions/side effects? Rapid heart rate What should be done in the event of reaction/side effect?	
Any precautions that school personnel need to know? Contraindications?	(This cell is merged with the previous one for the purpose of this exercise)	
<b>Check appropriate boxes below:</b> <input type="checkbox"/> I authorize this student to <b>self-administer</b> the above medication. <input type="checkbox"/> I authorize designated school personnel to assist the student with taking the above medication.		
Print name, address & phone number of Health Care Provider	Signature of Health Care Provider	Date

### 家長/監護人/看顧人填寫 部份

家長/監護人/看顧人姓名	在家所用語言	日間電話 ( )
地址 - 號碼及街名	公寓號碼      城市	晚間電話 ( )
學校	兒童中心 / 小學 / 初中 / 高中	上課時間
請在下面適當空格上劃“√” = <input type="checkbox"/> 本人允許子女自己服用以上藥物。 <input type="checkbox"/> 本人允許指定學校人員給本人子女服用以上藥物。		

1. 本人同意，三藩市聯合校區及其僱員無須為服藥的後果或服藥方法負任何責任。
2. 三藩市聯合校區及其僱員若因這些安排而需負責，本人將予賠償。
3. 子女服用的藥物如有改變，本人會立即通知校長。
4. 本人明白，本人送到學校的藥物需用藥房原裝藥瓶來裝，藥瓶需有標籤，標籤上需有本人子女姓名及醫護服務提供者的指示。
5. 本人明白，學年完結時，本表格將自動失效。
6. 為了本人子女的安全與健康著想，本人同意校方採取適當行動。

家長/監護人/看顧人簽名 \_\_\_\_\_ 日期 \_\_\_\_\_