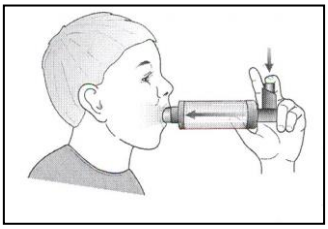
# San Francisco Unified School District



## 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) |
|---|---|---|---|
| | | | |

## HEALTH CARE PROVIDER SECTION

| | |
|---|---|
| Health Condition for which medication is prescribed:<br>**ASTHMA** | Quick Relief Asthma Medication: _____<br>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 | 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?<br>_____AM / PM |
| Any precautions that school personnel need to know?<br>Contraindications? | What are possible reactions/side effects? Rapid heart rate<br>What should be done in the event of reaction/side effect? |

**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 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<br>(  ) |
|---|---|---|---|---|
| 地址 – 號碼及街名 | 公寓號碼 | 城市 | 郵區編號 | 晚間電話<br>(  ) |
| 學校<br>兒童中心 /小學 /初中 /高中 | | | | 上課時間 |

**請在下面適當空格上劃"√"：**

❒ 本人允許子女自己服用以上藥物。

❒ 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. 爲**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_____