WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT

PUPIL SERVICES CENTER
2465 Dolan Way, San Pablo, CA 94806
Phone: (510) 307-4646 Fax: (510) 741-8971

SELF-ADMINISTRATION OF PRESCRIBED MEDICATION (INHALED)

_____ _____
School Date

Re:_____ _____
Student's Name Birth Date

Dear Doctor:

The parents of the above named student have advised us of your request to have their son/daughter carry an inhaler on his/her person to use for the relief of asthma symptoms in the classroom, in any area of the school or school grounds, during any school related activity and, upon specific request by a parent or guardian, in a private location.

In accordance with state law and school board policy, all medication administered during the school day shall be stored in the school health office and administered only when physician's and parents' forms are on file. However, the District will allow this student to carry medication and self-medicate upon approval of both the student's parents and physician. If, in your opinion, this student is able to self-care for his/her asthma through use of the inhaler, this student's medical condition requires immediate inhalation of prescribed inhaler, and this student's well-being is in jeopardy unless the inhaler is carried on his/her person, the statement below needs to be signed by you.

Thank you, School Nurse

_____ is under my care for asthma. His/her condition
Student's Name
warrants immediate inhalation of _____, and it is required that this medication be
Medication
carried on his/her person. This student has demonstrated knowledge of correct dosage and usage. The medication is to be used by the above student as follows:

_____ _____ _____
Dosage Time/Frequency Start/Stop Dates

The following is additional information relevant to the self-administration of the medication by the student:

_____

_____

_____ _____
Physician's Signature Address

_____ _____
Telephone Number Date

We, the parents of _____ desire the _____
Student's Name School
to comply with the orders of the above physician. We permit an authorized representative of the District to communicate directly with our child's physician, as may be necessary, regarding the physician's above statement. WE ASSUME ALL RESPONSIBILITY AND LIABILITY for the above medication when it is brought on campus by our son/daughter.

_____ _____
Parent/Guardian Date