PALOS VERDES PENINSULA UNIFIED SCHOOL DISTRICT
Health Services

SELF-ADMINISTRATION OF PRESCRIBED MEDICATION (INHALED)

______________________________ ____________________
PRINT Student's Name Date of Birth

______________________________ ____________________
School Grade

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 relief of asthma symptoms.

State law and school board policy requires all medication administered during the day be stored in the health office. If, in your opinion, this student's medical condition requires immediate inhalation of prescribed medication and 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/Health Clerk

____________________________is under my care for asthma. His/her condition
PRINT Student's Name

warrants immediate inhalation of ______________________________________
Medication

and it is required that this medication be carried on his/her person. This student has demonstrated knowledge of correct dosage and usage. Medication is to be used by the above student as follows:

_______________________ ________________________
Dosage Time/Frequency

_______________________ ________________________ ____________
Physician's Signature Address Date

WE ASSUME ALL RESPONSIBILITY AND LIABILITY for the above medication when it is brought on campus by our son/daughter.

_______________________________ _____________________
Parent/Guardian Date

This form must be renewed at the beginning of each school year.

H-1004