Asthma History

Authorization for Administration of Medication

dose and time *matches* *dose and time*

***********************IMPORTANT NOTE***********************

The completed forms AND prescribed medication must be received at the enrollment center before your child can attend preschool.

All medication must be in a pharmacy labeled box or in the original box/container (for over-the-counter medication).

Sacramento City Unified School District
Child Development Department

SCUSD Early Learning & Care Department

Asthma History

(Parent/Guardian to complete and return to Nurse)

Student Name: _____ Date of Birth: _____

Parent/Guardian Preschool:

_____ Weekly _____ Monthly _____ Seasonally _____ Other _____

How many times has your child been seen in the Emergency Room for asthma in the past year? _____

How many times has your child been hospitalized for asthma since birth? _____

How would you rate the severity of your child's asthma?
(Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

… Exercise
… Cigarette smoke
… Carpet
… Animal (Specify): _____
… Food (Specify): _____
… Other: _____
. Indoor dust
. Pollen
. Outdoor dust
… Respiratory Illness
… Strong chemicals
… Temperature change
… Wood smoke

What triggers your child's asthma?

Please list the medication/s your child takes for asth

Medication Name	Route given (Nebulizer, Inhaler	Amount	How Often

Will your child need rescue medication for asthma at school (such as Albuterol)? Yes/No

_____ _____ _____ _____
Parent Signature Date/Phone Nurse Signature Date

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Community, Health and Education Support Services Division
Health Services Office

AUTHORIZATION FOR ADMINSTRATION OF MEDICATION BY SCHOOL PERSONNEL

III. Parent Request

Please check one of these boxes.

5 I/We the undersigned, who am/are the parent(s) of _____ B B B B