

Atascadero Unified School District

5601 WESTMALL • ATASCADERO, CALIFORNIA 93422
DISTRICT OFFICE (805) 462-4200 • FAX (805) 462-4421

CONSENT FOR STUDENT TO CARRY MEDICATION

Please return this signed form to student's school

School:

Fax# for school:

Date:

To be filled out by doctor's office.

_____ has been instructed in the proper use of
 (inhaler/medication).
 Name of Medication _____ Reason to be given _____ D.O.B. _____
 Dosage _____ Frequency _____
 The child's well-being is in jeopardy unless the inhaler/medication is carried on his/her person.
 Therefore, we request that he/she be permitted to carry the inhaler/medication. He/she
 understands the purpose, appropriate method, and frequency of use of this inhaler/medication.

 Physician's Signature Date _____

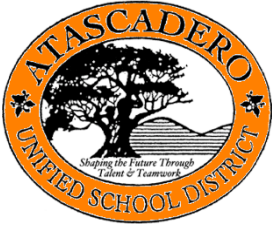
 Physician's Name Telephone _____

 Address _____

I permit my child to carry the above listed inhaler/medication as ordered by his/her physician. I understand that sharing medication with other students will result in disciplinary action. I also understand that school personnel are unable to monitor the frequency or method of usage of inhalers/medications when they are carried by the student. My child will carry the inhaler/medication for field trips. A backup inhaler/medication may be kept in the health room.

Parent/Guardian Signature

Date



Atascadero Unified School District

5601 WESTMALL • ATASCADERO, CALIFORNIA 93422
DISTRICT OFFICE (805) 462-4200 • FAX (805) 462-4421

CONSENTIMIENTO PARA QUE ESTUDIANTES PUEDAN TRAER CONSIGO SUS MEDICAMENTOS

Regrese esta información a la escuela del estudiante

School:

Fax# for school:

Date:

Para ser llenado por el consultorio del médico.

_____ has been instructed in the proper use of (inhaler/medication).	
Name of Medication _____	Reason to be given _____
D.O.B. _____	
Dosage _____	Frequency _____
<i>The child's well-being is in jeopardy unless the inhaler/medication is carried on his/her person. Therefore, we request that he/she be permitted to carry the inhaler/medication. He/she understands the purpose, appropriate method, and frequency of use of this inhaler/medication.</i>	
_____ <i>Physician's Signature</i>	_____ <i>Date</i>
_____ <i>Physician's Name</i>	_____ <i>Telephone</i>
_____ <i>Address</i>	

Yo permito que mi hijo/a traiga consigo el inhalador/medicamento que arriba se indica, tal como lo ha ordenado su médico. Yo entiendo que el compartir este medicamento con otros estudiantes resultará en una acción disciplinaria. También entiendo que el personal escolar no esta disponible para monitorear la frecuencia o el método de uso de inhaladores o medicamentos cuando estudiantes los traen consigo.

Firma del Padre o Guardián

Fecha