



# San Diego Unified School District

2351 Cardinal Lane, Annex B San Diego, CA 92123-3743

Nursing & Wellness Program  
Student Services Office  
(858)627-7580  
Fax: (858)627-7444

\_\_\_\_\_ School

Off-Campus Integrated Learning  
Experiences (OCILE) Program  
\_\_\_\_\_ **Old Town Program – 4<sup>th</sup> grade**  
Nurse – Telephone : (619) 293-4432  
Fax : (619) 298-1549

\_\_\_\_\_ **Balboa Park Program – 5<sup>th</sup> grade**  
Nurse – Telephone : (619) 293-4459  
Fax : (619) 686-6780

Dear Parent/Guardian:

Your child is scheduled to attend the program noted above on \_\_\_\_\_ and has a reported history of asthma. If your child uses an inhaler for asthma, at any time, it is required that they have it at the program. Increased exposure to the environment, along with increased exercise, often activates asthma. It is important for the nurses of these outdoor programs to have current information. Please complete the following and return as soon as possible to your school nurse.

Student's Name: \_\_\_\_\_

\_\_\_\_\_ My child no longer has asthma

\_\_\_\_\_ My child has mild asthma but does not require an inhaler while at the program

\_\_\_\_\_ My child has asthma. I will send medication(s)

**I will send these medications to school for the OCILE program:**

Inhaler Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Oral Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Pulmonaide Machine: \_\_\_\_\_

*(Medications must be labeled with child's name and instructions)*

I give permission for the school nurse or designee to administer the medication as indicated above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_