HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR ASTHMA

To Be Completed by Attending Physician
(Please Print or Type)

Demographic Information

Student's Name: _____ Birthdate: Month _____ Day_____ Year____

Ontario Health Card Number: _____

Description of asthma

The following triggers are likely to make the child's asthma symptoms worse:

☐ Colds/viral infections ☐ Animals ☐ Chalk Dust ☐ Strong Smells
☐ Exercise: (A **reliever medication** should be available to use 10-15 minutes *before* exercise)
☐ Weather Conditions: (please describe which weather conditions): _____
☐ Allergies (please specify): _____
☐ Other (please specify): _____

Symptoms: The following symptoms suggest the onset of the child's asthma or worsening of asthma:

☐ coughing ☐ wheezing ☐ shortness of breath ☐ chest tightness

☐ Other (please specify): _____

Medical Certification

This is to certify that _____ has asthma and may be given a Reliever Inhaler in the event of an asthma episode.

- Salbutamol (Ventolin, Airomir): 1 puff 2 puffs 1-2 puffs
- Terbutaline (Bricanyl): 1 puff 2 puffs 1-2 puffs
- Other: _____ 1 puff 2 puffs 1-2 puffs

Doctor's Name: _____ Telephone: _____

Doctor's Signature: _____ Date: Month _____ Day ____ Year _____

SS-06-58-INT (Copy to Documentation File of OSR and Student Medical File)

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR ASTHMA

To Be Completed by Parent/Guardian/Adult Student
(Please Print or Type)

Demographic Information

Student's Name: _____ Birthdate: Month____ Day ___ Year _____

Ontario Health Card Number: _____

Administration of Medication

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not trained medical personnel. However, I authorize the administration of a Reliever Inhaler, as prescribed by the attending physician, in the event that my child, _____ experiences an asthma episode on school property or during a school or school board sponsored event.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Principal Signature: _____ Date: Month _____ Day ___ Year _____

Self-Administration of Medication

I consent to have my child _____ carry a Reliever Inhaler on her/his person.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Principal Signature: _____ Date: Month _____ Day ____ Year _____

I consent to have my child _____ self-administer the Reliever Inhaler prescribed by the attending physician.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Principal Signature: _____ Date: Month _____ Day ____ Year _____

Posting of Photographs

I consent to the posting of photographs of my child _____

and of medical information (Individual Emergency Asthma Action Plan) in the following locations:

Classroom ☐ Lunchroom ☐ Staff Room ☐ Other ☐ _____

Office ☐ School Bus ☐ Resource Room ☐ _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Principal's Signature: _____ Date: Month _____ Day ____ Year _____

SS-06-58-INT (Copy to Documentation File of OSR and Student Medical File