

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR ASTHMA – PHYSICIAN and/or NURSE PRACTITIONER FORM**

To Be Completed by Attending Physician and/or Nurse Practitioner When the School Is First Informed of the Condition
and If Information Changes

(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:

- Animals Chalk Dust Colds/viral infections 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:

- chest tightness coughing shortness of breath wheezing
- 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 _____