Appendix B

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR ASTHMA – PARENT/GURADIAN FORM

To Be Completed by Parent/Guardian/Adult Student Annually
(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 **and/or nurse practitioner**, 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 **and/or nurse practitioner**.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Principal Signature: _____ Date: Month _____ Day _____ Year_____

I, _____ consent to carry a Reliever Inhaler on my person and to self-administer
(Student's name)
the Reliever Inhaler prescribed by my physician **and/or nurse practitioner**.

Adult Student Name: _____

Adult Student 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 Asthma Plan of Care) 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 .

Consent to the Development of an Individual Asthma Plan of Care

I consent to the development of an Individual Asthma **Plan of Care** for my child _____ _____. This plan will outline the emergency steps that shall be taken if my child experiences an asthma emergency on school property or during a school or school board sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my child's protection and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

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