Appendix A

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

**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_____

OEN: _____

**Description of asthma**

The following triggers are likely to make the student'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 student'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 _____

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