

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR ASTHMA – PARENT/GURADIAN/ADULT STUDENT FORM**

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

Demographic Information

Student's Name: _____ Birthdate: Month _____ Day _____ Year _____

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 I /my child, _____ experiences an asthma episode on school property or during a school or school board sponsored event.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student 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 myself/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/Adult Student Name: _____

Parent/Guardian/Adult Student 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 myself/my child _____
_____. This plan will outline the emergency steps that shall be taken if myself/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/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/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

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