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

Medical Health Practitioner Name: _____Telephone: _____

Medical Health Practitioner Signature: _____ Date: Month _____ Day ____ Year

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