



# Authorization for Administration of Reliever Medication & Asthma Standard Health Care Plan (SHCP)



School name: \_\_\_\_\_ School year: \_\_\_\_\_

**Student information**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Year Month Day

Address: \_\_\_\_\_

MHSC # (6 digit): \_\_\_\_\_ PHIN # (9 digit): \_\_\_\_\_

**Parent information**

Parent: \_\_\_\_\_ Daytime phone(s) \_\_\_\_\_

Parent: \_\_\_\_\_ Daytime phone(s) \_\_\_\_\_


Emergency contact: \_\_\_\_\_ Daytime phone(s) \_\_\_\_\_

**TRIGGERS - List items that most commonly trigger your child's asthma.**

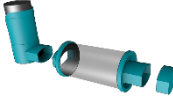
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<b>What Reliever medication has been prescribed for your child? (CHECK ONE)</b>	<input type="checkbox"/> Salbutamol (e.g. Ventolin®, Airomir®)
	<input type="checkbox"/> Symbicort® <input type="checkbox"/> Other _____
<b>How many puffs of Reliever medication are prescribed for an asthma episode? (CHECK ONE)</b>	<input type="checkbox"/> 1 puff <input type="checkbox"/> 1 or 2 puffs
	<input type="checkbox"/> 2 puffs <input type="checkbox"/> other _____
<b>Where does your child carry his/her Reliever medication? (CHECK ONE)</b>	<input type="checkbox"/> fanny pack <input type="checkbox"/> purse
	<input type="checkbox"/> backpack <input type="checkbox"/> other _____
<b>Does your child know when to take their Reliever medication?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Can your child take their Reliever medication on their own?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No


**CIRCLE the type of medication device your child uses for Reliever medication.**




Metered dose inhaler (MDI)




MDI & spacer with mouthpiece



MDI & spacer with mask



Turbuhaler®



Diskus®

**Parent authorization**

I understand that:

- Authorization to administer medication is renewed annually with student registration or upon a change in medication.
- The pharmacy label must be on the medication device.
- The parent is responsible for replacing expired medication as well as the removal and disposal of expired medication.

I hereby request and authorize the school to administer the medication named above to my child as outlined in the attached Asthma Standard Health Care Plan.

**Parent signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**School Administrator Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

