Authorization for Self-administration of Reliever Medication for Asthma
(To be completed by parent)

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)____ _____

Name of reliever medication

☐ Salbutamol (e.g. Ventolin®, Airomir)

☐ Symbicort®

☐ Other_____

Parent authorization

I acknowledge that my child can safely and responsibly carry and self-administer the medication named above during school hours and understand that I am responsible for consequences that may result from lost or misplaced medication.

Parent signature: _____ **Date:** _____