INTERLAKE SCHOOL DIVISION
Preparing Today's Learner for Tomorrow

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

School name: _____ **School year**: _____

Student information

Name: _____**Birthdate**: _____/_____/_____
Year Month Day

Address: _____

MHSC # (6 digit):_____ PHIN # (9 digit): _____

Parent/Guardian information

Parent/Guardian: _____Daytime phone(s) _____

Parent/Guardian: _____Daytime phone(s) _____

Emergency contact: _____Daytime phone(s)_____

Name of reliever medication

- ☐ Salbutamol (e.g. Ventolin®, Airomir)
- ☐ Symbicort®
- ☐ Other_____

Parent/Guardian 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/Guardian signature: _____ **Date:** _____