Appendix E

CONSENT FOR A CHILD TO CARRY AND SELF ADMINISTER ASTHMA MEDICATION

I hereby agree that _____:

___ can carry his/her prescribed medication and delivery devices to manage asthma while at school and during school related activities.
___ can self-administer his/her prescribed medication and delivery devices to manage asthma while at school and during school related activities.
___ requires assistance with administering his/her prescribed medications and delivery devices to manage asthma while at school and during school related activities.

I will provide the medication to the school in a container clearly labelled by the pharmacist and give any necessary instruction as to the storage of same medication. I will also inform the school of any change in medication or delivery device. I acknowledge that the medication supplied to the school cannot be beyond the expiration date.

Parent/Guardian Signature: _____ Date: _____

1. ***A new authorization form must be submitted each school year and whenever the medication(s)/procedure(s) is modified. This form must be retained in the school for one year after termination of medication/procedure.***
2. ***It is understood that the staff person is administering medication or providing service under the principle of "in loco parentis" and not as a health professional.***

NOTICE

Authorization for the collection and maintenance of the personal information recorded on this form is the Education Act, R.S.O. 1980, S.265 (d) and S.266 and the Municipal Freedom of Information and Protection of Privacy Act. Users of this information are Supervisory Officers, Principals and teachers at the school. Any questions regarding the collection of personal information should be directed to the Principal of the school.

I/We hereby consent to the use of personal information contained herein by the persons above-named and by such other officers or employees of the Board who may need the personal information in the performance of their duties as employees of the St. Clair Catholic District School Board.

Signature of Parent/Guardian: _____ Date: _____

FOR SCHOOL OFFICE USE
Medical Intervention Plan necessary: ☐ Yes ☐ No
If yes, attach a copy of the completed plan.
NOTE: **Medical Intervention Plan must be completed for anaphylactic shock and asthma and may be necessary for diabetes or epilepsy.**

SUPERVISION: Person(s) designated to supervise/administer medication(s)/procedure(s) and to maintain record:

Name: _____ Alternate: _____
(Signature) (Signature)

Principal's Signature: _____ Date: _____

Distribution: O.S.R.
School Office