Student Name
Student Photo

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

EMERGENCY CONTACTS (LIST IN PRIORITY)

DAILY/ ROUTINE ASTHMA MANAGEMENT

RELIEVER INHALER USE AT SCHOOL AND DURING SCHOOL -RELATED ACTIVITIES

Healthcare provider may include : Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
' This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW