Form 314-A4

Administration of Prescription Medication
Limestone District School Board

ASTHMA MANAGEMENT

Request and Authorization for the Administration of Reliever/Rescue Inhaler

I request that _____ ensures that _____ _____ receives the medication
School   Name of Student   DOB

prescribed by: _____ as attached.
                    (physician)

Notes: 1. The medication provided must be provided in the **ORIGINAL** prescription container, labeled with the name of the medicine, the physician's name, the amount to be taken and the time(s) to be taken, and the student's name. Prescription Number: _____

2. Check applicable boxes below:

☐ i) I authorize the principal or designate to administer the reliever/rescue inhaler.

☐ ii) I authorize my child to self administer the reliever / rescue inhaler.

On behalf of _____ and myself, I hereby **RELEASE THE BOARD,**
                    Name of Student

its agents, officers, officials and employees from any and all liability and from any and all actions, causes of actions, claims and demands of any nature arising out of or in any way related to the dispensing of the medication referred to herein by the said Board, its agents, officers, officials or employees.

Date: _____   Signed _____
                                        Parent/Guardian/Student (if not a minor)

Personal information on this form is collected under the authority of Board policy and will be used by school staff for the purpose of distributing medication as directed above. Questions about this collection may be directed to Board at 613.544.6920.

TO BE COMPLETED BY PHYSICIAN

The following medication has been prescribed. It is necessary for this medication to be administered during school hours by personnel other than the parent/legal guardian:

Medication/Dosage/Method of Administration/Frequency: _____

Indications for Administration: _____

Special Instructions: _____

Is student competent to use the medication independently?   YES ☐   NO ☐

Period of Authorization: From: _____   To: _____

Prescribing Physician's Name: _____

Address: _____   Telephone Number: _____

Date: _____   Signed: _____
                                        Physician

Note: This form is valid until the prescription expires or is altered by the physician, whichever comes first. It is the responsibility of the parent/guardian/student to ensure that a new form is completed when required and returned to the school. Any cost associated with the completion of this medical request is the sole responsibility of the parent/guardian.