

Scheme Name: _____ Date: _____

Physician: _____ Date: _____

Child's Full Name: _____

Educator's Full Name: _____

Name of Medication: _____

Storage Requirements: _____

Dosage and Frequency: _____

Date of last Dosage: _____

Time of last Dosage: _____

How does this medication affect your child?

How this medication is administered. (i.e. spacer/orally). _____

➤ Short Term medication: Date From: _____ to _____

This form is to be completed every day that medication is required!

➤ Long Term Medication: Date From: _____ to: _____

Long term medication Form and Doctor's Certificate are subject to 6 monthly review of if there are changes to the medication dosage.

I hereby give my permission for the above dosage to be administered to my child.

PARENT NAME: _____ DATE: _____

PARENT SIGNATURE: _____

I hereby give my permission for my school aged child to self-administer their asthma medication.

PARENT NAME: _____ DATE: _____

PARENT SIGNATURE: _____

