Plan of Care:
ASTHMA
School Year: 20__-20__

Student Name	DOB	Gender	Student Photo
Address		Student #	
Exceptionality:	Medic Alert I.D. Yes ☐ No ☐	OEN#	
1.			
2.			
3.			
Grade	Age	Teacher(s)	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

SUPPORTS FOR ASTHMA

Name of trained individuals who will provide support with Asthma related tasks:

Designated Staff: 1. _____ 2. _____ 3._____

LHIN/CCAC Care workers (if applicable): _____

Method of home-school communication:_____

Any other medical condition or allergy? ☐no ☐yes (list below):
1._____ 2._____

Use of Reliever Medication and Controller Medication at school and during out of school activities
A. ☐student **will carry and/or self-administer** reliever/controller medication in all settings as prescribed. Reliever/controller medication is kept: ☐pocket/person ☐backpack/fanny pack ☐case/pouch ☐other: (specify) _____
B. ☐student **requires assistance to administer** reliever/controller medication in all settings as prescribed. Please explain: _____ _____ _____ ☐back-up reliever inhaler is available and will be kept in the main office

The supervising teachers will have back up reliever inhaler during sporting events, excursions, and all other out of school activities to be used in emergency situations.

Each time staff administer prescribed asthma medication information must be recorded on the: Student Log of Administered Medication form.

Known Asthma Triggers Check all those that apply
☐colds/flu/illness ☐change in weather ☐ pet dander ☐strong smells ☐smoke (i.e. tobacco, fire, cannabis, second-hand smoke) ☐mould ☐dust ☐pollen ☐cold weather ☐physical activity/ exercise ☐allergies (specify): _____ ☐at risk for anaphylaxis (specify allergen): _____ ☐asthma trigger avoidance instructions: _____ _____ ☐any other medical condition or allergy: _____ _____

Reliever Inhaler use at school and during school related activities

A **reliever inhaler is a fast acting medication (**usually blue in colour) that is used when someone is having asthma symptoms. The reliever inhaler should be used:

☐when student is experiencing asthma symptoms (i.e. trouble breathing, coughing, wheezing).
☐other (explain): _____

Use of reliever inhaler _____ in the dose of _____
(name of medication) (# of puffs)
Spacer (valved holding chamber) provided ☐ Yes ☐ No image

Place a check mark beside the type of **reliever inhaler** that the student uses:
☐salbutamol (image) ☐airomir (image) ☐ventolin (image) ☐bricanyl (image)
☐other (specify): _____

EMERGENCY PROCEDURES DURING ASTHMA ATTACK

IF ANY OF THE FOLLOWING OCCUR:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)
- Student may also be restless, irritable and/or quiet

TAKE ACTION:

STEP 1: Immediately use fast-acting relieve inhaler (usually blue inhaler). Use a spacer if provided.

STEP 2: Check symptoms. Only return to normal activity when all symptoms are gone. If symptoms persist, do not improve within 10 minutes or get worse, this is an **EMERGENCY!** Follow the steps below:

IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin or neck or chest sucked in with each breath
- Student may also be anxious, restless and/or quiet

THIS IS AN EMERGENCY:

STEP 1: IMMEDIATELY USE ANY FAST-ACTING RELIEVER (USUALLY A BLUE INHALER). USE A SPACER IF PROVIDED.
Call 9-1-1 for an ambulance. Follow 9-1-1 communication protocol with emergency responders.

STEP 2: If symptoms continue, use reliever inhaler every 5-15 minutes until medical attention arrives.

While waiting for medical help to arrive:

- Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction)
- Do not have the student breathe into a bag
- Stay calm, reassure the student and stay by his/her side
- Notify parent(s)/guardian(s) or emergency contact

Controller Medication use at school and during school related activities

Controller medication are taken regularly every day to control asthma. Usually, they are taken in the morning and at night, so generally not taken at school (unless student will be participating in an overnight activity).

Place a check mark beside the type of prescribed **controller medication** that the student uses:
☐flovent (image) ☐advair (image) ☐qvar (image) ☐pulmicort (image)
☐other (specify): _____

Use/administer _____ in the dose of _____ at the following times _____
(name of medication)

Use/administer _____ in the dose of _____ at the following times _____
(name of medication)

Use/administer _____ in the dose of _____ at the following times _____
(name of medication)

Consent for student to carry and self-administer asthma medication

We agree that _____,
(student name)
☐can **carry** prescribed medications and delivery devices to manage asthma while at school and during school-related activities.
☐can **self-administer** prescribed medications and delivery devices to manage asthma while at school and during school-related activities.
☐**requires assistance** with administering prescribed medications and delivery devices to manage asthma while at school and during school-related activities.

☐**It is the parent/guardian responsibility to notify the principal if there is a need to change the plan of care during the school year and to inform the school of any change of medication or delivery device**. This medication **cannot** be beyond the expiration date. **This plan remains in effect for the 20__--20__ school year without change and will be reviewed on or before: _____.**

Parent/Guardian Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Student Name: _____ Signature: _____ Date: _____

Principal Name: _____ Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION (MANDATORY)

To be included by healthcare professional (I.E.: Pharmacist, Respiratory Therapist, Certified Asthma Educator, Certified Respiratory Educator, Nurse, Medical Doctor or other clinician working within their scope of practice)

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels/Comments:

_____

_____

_____

_____

- If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization 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

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1.	2.	3.
4.	5.	6.

Other individuals to be contacted regarding Plan of Care:

Before-School Program ☐ Yes ☐ NO
_____

After-School Program ☐ Yes ☐ NO
_____

School Bus Driver/Route # (If applicable)_____

Other: _____

This plan remains in effect for the 20____ - 20 ____ school year without change and will be reviewed on or before _____.

It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.

Parent(s)/Guardian(s): Date:
_____ _____
(signature)