ASTHMA HEALTH CARE PLAN

STUDENT INFORMATION

Student Name_____ Date Of Birth_____

Age _____

Grade_____ Teacher(s)_____

Student Photo (optional)

EMERGENCY PROCEDURES

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 reliever inhaler (usually a blue inhaler). Use a spacer if provided.

STEP 2: Only return to normal activity when all symptoms are gone.
If symptoms get worse or do not improve within_____minutes, this is an **EMERGENCY!**
Follow 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
- Other _____

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_____minutes until medical attention arrives.

Form P662.3, September 2018

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.

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DAILY/ ROUTINE ASTHMA MANAGEMENT

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 (e.g., trouble breathing, coughing, wheezing).

❒ Other (explain): _____

Use reliever inhaler _____ in the dose of _____
(Name of Medication) (Number of Puffs)

Spacer (valved holding chamber) provided? ❒ Yes ❒ No

❒ Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible**.

Reliever inhaler is kept:
❒ With _____ Location: _____ Other Location: _____

❒ Student **will carry** their reliever inhaler **at all times** including during recess, gym, outdoor and off-site activities.

Reliever inhaler is kept in the student's:

❒ Pocket ❒ Backpack/fanny Pack
❒ Case/pouch ❒ Other (specify): _____

Does student require assistance to **administer** reliever inhaler? ❒ Yes ❒ No

❒ Student's **spare** reliever inhaler is kept:

❒ In main office (specify location): _____ Other Location: _____

CONTROLLER MEDICATION USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITES

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

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)

Storage and location of spare medication and other supplies if applicable:

_____

_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

_____

_____

KNOWN ASTHMA TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

❒ Colds/Flu/Illness	❒ Change In Weather	❒ Pet Dander	❒ Strong Smells	
❒ Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)	❒ Mould	❒ Dust	❒ Cold Weather	❒ Pollen
❒ Physical Activity/Exercise	❒ Other (Specify) _____			

❒ At Risk For Anaphylaxis (Specify Allergen) _____

❒ Asthma Trigger Avoidance Instructions: _____

❒ Any Other Medical Condition or Allergy? _____

_____

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:_____unless otherwise notified by parent(s)/guardians of need to revisit the Plan. (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.)

I/We hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures. Parent(s)/guardians and students acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardians to ensure that clear instructions and current physician's orders are provided to the principal.

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

Signature

Student:_____ Date:_____

Signature

Principal:_____ Date: _____

Signature

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

Distribution: Original: Secure location accessible by school staff

Original: Scanned and uploaded to SSNET

Original: Scanned and sent to Student Transportation Services

Copy: Parent/Guardian

Copy: File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

P662.02 Staff Administration of Medication

P662.03 Self-Administration of Medication

Medical Incident Record Form