

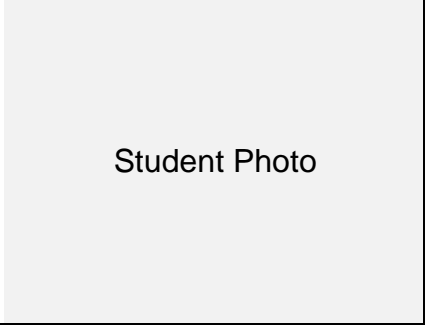
PREVALENT MEDICAL CONDITION — ASTHMA
Plan of Care

STUDENT INFORMATION

Student Name: _____ Date Of Birth: _____

OEN: # _____ Age: _____ Grade: _____ Weight: _____

Program: IET / RESOURCE Teacher(s): _____



EMERGENCY CONTACTS (LIST IN PRIORITY)

First contact must be a parent.

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN ASTHMA TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

<input type="checkbox"/> Colds/Flu/Illness	<input type="checkbox"/> Change In Weather	<input type="checkbox"/> Pet Dander	<input type="checkbox"/> Strong Smells
<input type="checkbox"/> Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)	<input type="checkbox"/> Mould	<input type="checkbox"/> Dust	<input type="checkbox"/> Cold Weather
<input type="checkbox"/> Physical Activity/Exercise	<input type="checkbox"/> Other (Specify) _____		
<input type="checkbox"/> At Risk For Anaphylaxis (Specify Allergen) _____			
<input type="checkbox"/> Asthma Trigger Avoidance Instructions: _____			
<input type="checkbox"/> Any Other Medical Condition Or Allergy? _____			

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

Place a (✓) check mark beside the type of reliever inhaler the student uses:

Airomir Ventolin Bricanyl Other (Specify) _____

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 SCHOOL-RELATED ACTIVITIES

Controller medications are taken regularly every day to control asthma. Usually, they are taken in the morning and at night, so generally not taken at school.

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)

To administer prescribed medication, the following section must be completed by a physician.

Name of Medication

Method of Administration (*Dosage, time of administration*)

Additional Instructions

Name of Physician (*please print*)

Phone #

Signature of Physician

Date

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: Notify BSA School Nurse STAT and immediately use fast-acting reliever inhaler (usually a blue inhaler) as prescribed.

STEP 2: Check symptoms. Only return to normal activity when all symptoms are gone. If symptoms get worse or do not improve within 10 minutes after rescue medication is administered, this is an **Emergency**. Follow steps below.

IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Lips or nail beds are blue or grey
- Skin or neck or chest sucked in with each breath
- Become unresponsive/unconscious

THIS IS AN EMERGENCY

STEP 1: If symptoms continue call **Code Blue** ext. 5555

STEP 2: Notify Parent/Guardian/Emergency Contact (see page 1)

AUTHORIZATION/PLAN REVIEW

I/we authorize the principal or principal designate to share the Plan of Care with school staff who are in direct contact with my child. For example the classroom teacher, educational assistants, therapy team, rotary teachers, occasional staff, appropriate Holland Bloorview staff such as Spiral Garden and pool, transportation providers and volunteers.

Other individuals to be contacted regarding Plan of Care: _____

This plan remains in effect for the completion of the school year and will be reviewed annually. It is the parent's responsibility to notify the principal if there is a need to change the Plan of Care during the school year.

I/we understand our child's personal health information will be disclosed between organizations to maximize the quality of education being provided to our child and this information will be held in confidence and maintained securely in accordance with Ontario's privacy law called the Personal Health Information Protection Act (PHIPA).

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

Principal: _____ Date: _____