Student Plan of Care for ASTHMA

School Year: 20 -20

Student Name	Date of Birth	Gender	Student Photo
Address		Student #	
Exceptionality	Teacher(s)	Medic Alert I.D. Yes ☐ No ☐	
Grade	Age	OEN #	

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:_____

Local Health Integration Network (LHIN) Care Workers (if applicable):

_____

Method of home-school communication:_____
Any other medical condition or allergy? ☐ No ☐ Yes (Please list below)

1. _____
2. _____
3. _____

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:

_____

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: School Record of Medical Services Form (Appendix B).

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

Controller Medication use at school and during 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 (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 ☐ advair ☐ qvar ☐ pulmicort
☐ other (specify): _____

Use/administer _____ in the dose of _____ at the following time(s): _____
(Name of Medication)

Use/administer _____ in the dose of _____ at the following time(s): _____
(Name of Medication)

Use/administer _____ in the dose of _____ at the following time(s): _____
(Name of Medication)

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 reliever inhaler (usually a 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

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.

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

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

Student Name: _____ Signature: _____ Date: _____

Principal Name: _____ Signature: _____ Date: _____

EXCURSION PROTOCOL

Please refer to the Excursion Handbook when planning for excursions and ensure that accommodations are made for the student with Asthma:
https://www.tcdsb.org/ProgramsServices/SchoolProgramsK12/HealthOutdoorPhysEd/ExcursionHandbook/Documents/Excursion-Handbook-updated-Nov-30-2015.pdf

During all trips off school property, the parent/guardian will provide an excursion kit which will consist of:

☐ Inhalers (refer to Excursion Handbook for further information)

☐ Emergency Contact

☐ Cell phone (if parent/guardian chooses)

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/Phone Number: _____

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 to administer applies, and possible side effects. This medication cannot be beyond the expiration date. 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 and to inform the school of any change of medication or delivery device during the school year.

Consent to treatment: I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their abilities and in good faith.

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

Student: _____ Date: _____
(signature for student 16 years of age or older)

Principal: _____ Date: _____
(signature)