JAMES BAY LOWLANDS SECONDARY SCHOOL BOARD

PREVALENT MEDICAL CONDITION — ASTHMA PLAN OF CARE

STUDENT INFORMATION Student Photo

Student Name ______________________ Date of Birth ______________

Ontario Ed. # _______________________ Age _____________________

Teacher(s) _________________________ Grade ___________________

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
1.			
2.			
3.			

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?

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 ____ (Name of Medication)
in the dose of ______________________(Number of Puffs)
Spacer (valved holding chamber) provided? ☐ Yes ☐ No

✓ Place a check mark beside the type of reliever inhaler that 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 ______________________ [Name individual] Location: __________________________

OR Other Location: _______________________________________
☐ In locker # _______Locker Combination: ___________________

☐ 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 _____________________________
Other Location: _____________________ ☐In locker #: _____________
Locker Combination: ________________

CONTROLLER MEDICATION USE AT SCHOOL AND AT SCHOOL-RELATED ACTIVITES

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 the student will be participating in an overnight activity).

Use/administer ______________________ (Name of Medication) in the dose of _____________
at the following times: __________________

Use/administer ______________________ (Name of Medication) in the dose of _____________
at the following times: __________________

IF ANY OF THE FOLLOWING OCCUR:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)
- Note: 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 get worse or do not improve within 10 minutes, this is an **EMERGENCY!**

Follow steps below:

IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Student cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin on neck or chest is sucked in with each breath
- Note: 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.
When 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 or her side.
- ✓ Notify the parents or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name:
Profession/Role:
Signature:
Date:
Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency, and method of administration, dates for which the authorization to administer applies, and possible side effects.
*Note: 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 the 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 parents' responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent: ____ Date: ______________
Signature
Student: ____ Date: ______________
Signature
Principal: ____ Date: ______________
Signature