APPENDIX B: PLAN OF CARE — ASTHMA

STUDENT INFORMATION

School	Age	Homeroom Teacher	Student Name

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Any other medical condition or allergy? _____

MedicAlert® ID ☐ Yes ☐ No

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

KNOWN ASTHMA TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

☐ Colds/Flu/Illness	☐ Weather (cold/hot/humid)	☐ Pets/Animals	☐ Strong Smells
☐ Vape/Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)	☐ Mould	☐ Dust	☐ Pollution
			☐ Pollen
☐ Physical Activity/Exercise	☐ Strong Emotions (e.g., anxiety, stress, laughing, crying, etc.)	☐ Other (Specify) _____	

☐ At Risk For Anaphylaxis (Specify Allergen) _____

☐ Asthma Trigger Avoidance Instructions: _____

_____

APPENDIX B: PLAN OF CARE — ASTHMA

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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 of _____ in the dose of _____ as needed.
(Name of Medication) (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/Salbutamol ☐ Ventolin/Albuterol ☐ Bricanyl/Terbutaline ☐ Other (Specify) _____

☐ Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible (i**n accordance to Ryan's Law)

Reliever inhaler is kept:

☐ With _____ Location: _____ Other Location: _____

■ In locker # _____ Locker Combination: _____

☐ Student **will carry** their reliever inhaler **at all times** including in the classroom, outside the classroom (e.g., library, cafeteria/lunchroom, gym) and off-site (e.g., field trips/excursions)

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: _____

☐ In locker #: _____ Locker Combination: _____

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 the 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)

Note: Ask parents/guardians for the child's **Asthma Action Plan** and go over it with them. Download the Action Plan here or visit https://lunghealth.ca/resource-library/

APPENDIX B: PLAN OF CARE — ASTHMA

STUDENT INFORMATION

School	Age	Homeroom Teacher	Student Name

EMERGENCY PROCEDURES

FOR MANAGEMENT

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 get worse or do not improve within 10 minutes, this is an **EMERGENCY!**
Follow steps below.

FOR AN EMERGENCY

IF ANY OF THE FOLLOWING OCCUR:

- Reliever puffer **lasts less** than 3 hours
- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin on neck or chest sucked in with each breath

(*Student may also be anxious, restless, and/or quiet.)

EMERGENCY ACTION:

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 their side.
- ✓ Notify parent(s)/guardian(s) or emergency contact.

APPENDIX B: PLAN OF CARE — ASTHMA

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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.
✸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

Please select one of the following:

☐ DSBN Teaching and Support Staff, Niagara Student Transportation Services and food service providers.

☐ Only those listed below:

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

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

Personal information and personal health information on this form is collected, used and disclosed in accordance with the Education Act, R.S.O. 1990, c.E.2, as amended, the Municipal Freedom of Information and Protection of Privacy Act. R.S.O 1990, c.M. 56, as amended and the Personal Health Information Protection Act, 2004, c.3 Sched. A., as amended and will be used for the purpose of providing student health information for the Plan of Care and any similar or related purpose(s). Questions about this collection, use and disclosure should be directed to the Freedom of Information Coordinator, District School Board of Niagara, 191 Carlton Street, St. Catharines, ON L2R 7P4 905-641-1550