CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO

PREVALENT MEDICAL CONDITION – ASTHMA

Plan of Care (Sample)

STUDENT INFORMATION:

Student Name_____ Date of Birth_____

Ontario Ed. #_____ Age_____

Grade_____ Teacher(s)_____

Student Photo (optional)

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	☐ 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 _____ 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 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 _____ – location: _____ 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 (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

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: 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
- 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.

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

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 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) or student 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