

PREVALENT MEDICAL CONDITION — ASTHMA

Plan of Care

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	☐ Other (Specify) _____		
☐ Physical Activity/Exercise			
☐ 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 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 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: _____

If medication is prescribed and will be administered at school, it is necessary to complete the following document:

1) Form 314-A4: "Request and Authorization for the Administration of Reliever/Rescue Inhaler"

Is Form 314-A4 required for this student? ☐ Yes ☐ No

TRANSPORTATION

Plan for Student Transportation

Individual Student Boarding	Individual Student Securement	Individual Student De-Boarding

Roles

School Staff	Parent/Guardian	Student	Transportation Provider	Operator/Driver
-Create and monitor this plan with parents/guardians, student, TriBoard, and school staff. -Advise TriBoard and parents/guardians of relevant issues while at school during the day.	-Communicate with the school any medical or other conditions affecting the safe transportation of the student for completion of this plan.	-Follow the bus rules and strategies listed on this plan. -Advise the driver of any medical emergency, or health issues that they are experiencing while being transported.	-Ensure that all drivers and monitors staffed to transport the student are aware of the strategies listed in this plan. -Ensure that all temporary staff that transport the student are aware of the	-Ensure that the student is transported safely according to needs listed on this plan. -Follow TriBoard and School Board policies and procedures for transporting students with disabilities.

-Help identify tools, or strategies that may help the driver and/or monitor while transporting the student.	-Communicate any changes to any medical or other conditions that might affect transportation. -Communicate with the school and driver any tool or strategies that will help the driver deliver and monitor the needs of the student while transporting them.	-Communicate with the driver if a listed strategy on this plan needs to be addressed or revisited for their comfort (if possible).	strategies listed in this plan. -Ensure that all temporary staff that transport the student are fully briefed on this plan. -Ensure that proper training of staff is in place regarding boarding, securing, and de-boarding practices to transport student.	-Communicate with school staff and parents/guardians any concerns, or adjustments that need to be made to this plan.
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AUTHORIZATION / USE OF INFORMATION /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) _____

All bus drivers are certified in the administration of First Aid, CPR, and Epi-Pen. These are the only medical procedures a driver may perform. In the event of a student showing signs of medical distress during travel on the school bus, the driver will stop the vehicle in the first safe location, assess the situation, determine if an epi-pen needs to be administered, immediately contact the Bus Operator to request emergency services. The driver will remain with the student until the arrival of the emergency services team. Should a bus driver have occasion to administer First Aid, CPR, or an Epi-Pen, he/she does so in applying the "in loco parentis" principle, not as a health care professional. Visit triboard.ca for complete procedure details. (Tribord)

I consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Limestone District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

- ☐ classroom ☐ other: _____
☐ office

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

☐ ***Please Note: Checked box indicates that this student has an additional Plan of Care***