FORM Nbr: SA 10117
DATE: June/19

PREVALENT MEDICAL CONDITION-ASTHMA
PLAN OF CARE

STUDENT INFORMATION

Student Photo

Student Name _____ Date of Birth_____

Ontario Ed #_____ Age_____

Grade_____ Teacher_____

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

KNOWN ASTHMA TRIGGERS – (check all 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 symptons. The reliever inhaler should be used:

- ☐ When student is experiencing asthma symptons (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

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What to look for (1 or more)	MILD ASTHMA SYMPTOMS	ASTHMA EMERGENCY
	□ continuous coughing □ complaints of chest tightness □ difficulty breathing □ wheezing (not always present (Above symptoms may also be accompanied by: restlessness, irritability, tiredness)	**ANY** of the following symptoms indicate an emergency! □ unable to catch breath □ difficulty speaking a few words □ lips or nail bed blue or grey □ breathing is difficult & fast (greater than 25 breaths per minute)
What to do in an emergency	1. Administer reliever inhaler. If there is no improvement in 5 to 10 minutes **THIS IS AN EMERGENCY** 2. Stay calm. Remain with child. 3. Tell the child to breathe slowly & deeply 4. Notify parent of episode 5. Child can resume normal activities once feeling better	**1. CALL 911** **2.** Give reliever inhaler immediately & continue to use reliever inhaler every ____ minutes until help arrives **3.** Stay calm. Remain with the child **4.** Tell child to breathe slowly & deeply

Healthcare provider may include: Physician or Nurse Practitioner

Healthcare Provider's Name:_____

Profession:_____

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. _____ 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