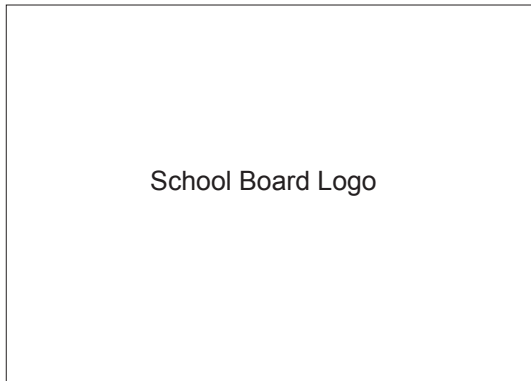
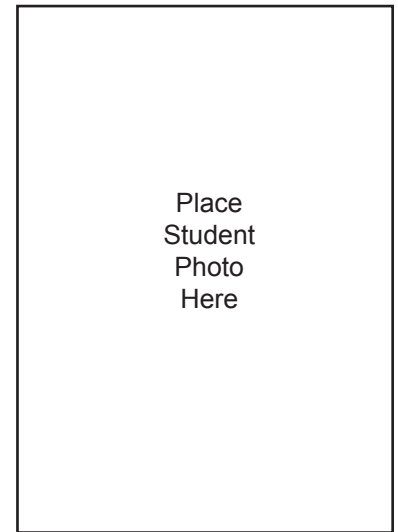


# INDIVIDUAL STUDENT ASTHMA MANAGEMENT PLAN



School Board Logo



Place Student Photo Here

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Ontario Education Number \_\_\_\_\_ Age \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

## Emergency Contacts (list in priority of contact):

	Name	Relationship	Daytime Phone	Alternate Phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

## KNOWN ASTHMA TRIGGERS

- Colds/flu/illness  Physical activity/exercise  Pet dander  Cigarette smoke  Pollen  Mould  
 Dust  Cold weather  Strong smells  Allergies (specify): \_\_\_\_\_  
 Anaphylaxis (specify allergy): \_\_\_\_\_  Other (specify): \_\_\_\_\_


Asthma trigger avoidance instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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:

- Salbutamol (e.g. Ventolin)   Airomir   Ventolin   Bricanyl   Other (specify): \_\_\_\_\_

Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible** by teacher/supervisor.

Reliever inhaler is kept:

- With teacher/supervisor - location: \_\_\_\_\_
- In locker #: \_\_\_\_\_ Locker combination: \_\_\_\_\_
- Other location (specify): \_\_\_\_\_

Student **will carry** his/her reliever inhaler **at all times** including during recess, gym, outdoor and off-site activities, and field trips.

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): \_\_\_\_\_
- In locker #: \_\_\_\_\_ Locker combination: \_\_\_\_\_
- Other location (specify): \_\_\_\_\_

## CONTROLLER MEDICATION USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITIES

Controller medications are usually taken regularly every day to control asthma. Usually, they are taken in the morning and at night, so generally not taken to 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)

## CONSENT FOR STUDENT TO CARRY AND SELF-ADMINISTER ASTHMA MEDICATION

We agree that \_\_\_\_\_:  
(Student Name)

- can **carry** his/her prescribed medications and delivery devices to manage asthma while at school and during school-related activities.
- can **self-administer** his/her prescribed medications and delivery devices to manage asthma while at school and during school-related activities.
- requires assistance** with administering his/her prescribed medications and delivery devices to manage asthma while at school and during school-related activities.

We will inform the school of any change in medication or delivery device. The medications **cannot** be beyond the expiration date.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Phone #:

Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_ Alternate: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PLAN REVIEW

Optional review by health-care provider (e.g., Pharmacist, Respiratory Therapist, Certified Asthma Educator, Certified Respiratory Educator, Nurse, Medical Doctor, or other clinician working within their scope of practice):

Attach prescription labels here

Health-Care Provider's Name: \_\_\_\_\_ Profession: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Names of staff with first aid training

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Principal's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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