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:

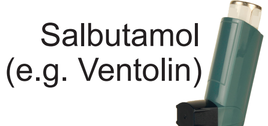
☐ When student is experiencing asthma symptoms (e.g., trouble breathing, coughing, wheezing).

☐ 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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