fraser academy

ASTHMA PLAN 2020-2021

Student Details

Affix student photo here

Student Name

Grade

Care Card Number (PHN)

Date of Birth (DD/MM/YYYY)

Mother/Guardian's Name

Mother/Guardian's Phone

Father/Guardian's Name

Father/Guardian's Phone

Alternate Emergency Contact

Phone Number

Known Asthma Triggers

E.g. allergies, smoke, pollen, colds/flu, exercise. Please describe:

Asthma Risk History

Has the student had previous asthma attack requiring hospitalization? ☐ Yes ☑ No

Does the student have an **Anaphylactic Allergy**? ☐ Yes* ☑ No ** Please also fill out an* ***Anaphylaxis Plan*** *form*

If Yes, what are the allergen(s)?

Note: If the student is having an anaphylactic reaction and has difficulty breathing, the EPIPEN will be administered prior to the asthma medication.

Asthma Medication

Reliever Inhaler

Dosage & Frequency

Does the student use a spacer (e.g. Aerochamber) with their inhaler? ☐ Yes ☑ No

Other Asthma management medications, dosage, frequency

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Reliever Inhaler at School

The student wil carry their reliever inhaler at all times, inluding during recess, PE, outdoor and off-site activities, field trips and on school buses. If the student uses a spacer, this should be carried with them as well.

The reliever inhaler is kept in the student's

Backup Inhaler

A backup reliever inhaler will be kept on the 5th floor, and will also be signed out for any field trips. If a student uses a spacer or other medications, please provide this as well.

Backup Inhaler Expiry Date:

Administration of Medications

If the student requires assistance with any medications, please also fill out the **Administration of Medication** form.

Exercise Procedure

If exercise/physical activity triggers the student's asthma, list steps the student should follow prior to physical activity:

Student Asthma Self-Management Plan [Faculty supervised]

Usual Asthma Symptoms:

Check all that apply:

- ☐ Cough
- ☐ Wheeze
- ☐ Shortness of Breath
- ☐ Chest tightness
- ☐ Other (please describe):

If the student is experiencing asthma symptoms:

Have the student sit down and rest.

Have the student administer their reliever inhaler as per instructions.

Monitor student and check in with regarding symptoms.

Have the symptoms resolved after treatment? (5-10 minutes)

Yes - student can return to normal activity

No - call for a first aid attendant to follow the first aid plan

FIRST AID ASTHMA PLAN

Step 2: If the student has taken their rescue inhaler, and continues to have asthma symptoms:

- ☐ Have the student take another dose of their reliever inhaler: ____ puffs.
- ☐ Phone parent / guardian and follow their direction
- ☐ Other - Please specify: ____

Step 3: If there is still no improvement then:

Step 4: If the symptoms do not improve or return, call 9-1-1 for an ambulance

Emergency symptoms:

- Breathing is difficult and fast
- Coughing or wheezing non-stop
- Unable to complete sentences due to shortness of breath
- Blue/grey lips or fingernails
- Skin sucking in between ribs, or base of throat
- Sweating

The student may also seem anxious, restless, and/or very tired.

While waiting for the paramedics:

Continue to use reliever inhaler as needed until paramedics arrive. Administer ____ puffs every ____ minutes.

Have the student sit up with arms resting on a table (do not have the student lie down unless it is an anaphylactic reaction)

Notify parents. If parents can't be reached, notify emergency contacts.

Additional Asthma Plan Instructions:

Parent Authorization

I agree with the plan of care outlined in this document. I am aware that the school staff are not medical professionals and will perform all aspects of the plan to the best of their ability and in good faith.

I understand that it is my responsiblity to provide an updated plan for each new school year, as well as if my child's condition, asthma plan, and/or medication changes. If I wish to cancel this plan, I will do so in writing.

I authorize the school to share this plan and it's information with any relevant staff, for the purposes related to education, health and safety of my child. Information shared will be subject to the school's Privacy Policy.

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

Physician Authorization

I have reviewed and am in agreement with the information contained in this Asthma Plan.

Signature of Physician	Physician Name	Date (DD/MM/YYYY)

Physician's Address	Physician's Phone