fraser academy

ASTHMA PLAN 2021-2022

Student Details

Affix student photo here

Student Name

Grade

BC Services Card Personal Health Number (PHN)

Date of Birth (DD/MM/YYYY)

Parent/Guardian 1 Name

Parent/Guardian 1 Phone

Parent/Guardian 2 Name

Parent/Guardian 2 Phone

Alternate Emergency Contact

Phone Number

Known Asthma Triggers

E.g. allergies, smoke, pollen, colds/flu, exercise, stress, cold air, strong scents. Please describe:

Usual Asthma Symptoms

Check all that apply:

- ☐ cough
- ☐ wheeze
- ☐ shortness of breath
- ☐ chest tightness
- ☐ difficulty speaking
- ☐ other (please describe):

Asthma Risk History

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

What is the frequency and severity of asthma flare-ups?

Does the student have an **anaphylactic allergy**? ☐ Yes* ☐ No ** Please also fill out an **Anaphylaxis Plan** form.*

If Yes, what are the allergen(s)?

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ASTHMA PLAN
2021-2022

Asthma Medications

Asthma Rescue Medication - "Reliever Inhaler"

The student will carry their reliever inhaler at all times, including during recess, PE, outdoor and off-site activities. If the student uses a spacer, this should be carried with them as well.

Reliever Inhaler _____ Dosage & Frequency _____

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

The reliever inhaler is kept in the student's _____

Backup Reliever Inhaler

A second (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 _____ Spacer Included ☐ Yes ☐ No

Other Asthma Medications

Please list any other medications your child uses to control their asthma. E.g. other inhalers, antihistamines, etc. Please note if they may need to take any of these at school.

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

Exercise & Activity Procedure

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

ASTHMA FIRST AID PLAN

Student _____

Step 1: If the student is experiencing asthma symptoms:

- Have the student sit down (staying upright) and rest
- Have the student administer their reliever inhaler
- Monitor student and symptoms

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

Yes: student can return to normal activity, slowly

No: call for a first aid attendant to follow the first aid plan (Step 2 or 3)

Step 2: If the student continues to have asthma symptoms:

- Have the student administer another _____ puffs of their reliever inhaler
- Phone parent / guardian and follow their direction

Step 3: If the symptoms return, do not improve, or the student has any of the emergency symptoms below, call 9-1-1 for an Ambulance

Inform the 911 operator that a student is having an asthma attack.

While waiting for the paramedics:

- Continue to use reliever inhaler as needed until paramedics arrive. Administer _____ puffs every _____ minutes.
- Notify / update parents. If parents can't be reached, notify emergency contacts.

Additional Asthma Plan Instructions / Notes:

Emergency symptoms:

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

May also appear anxious, restless, and/or very tired.

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 responsibility 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 its information with any relevant staff, for the purposes related to the education, health and safety of my child. Information shared will be subject to the school's Privacy Policy.

Signature of Parent/Guardian 1	Parent/Guardian 1 Name	Date (DD/MM/YYYY)

Signature of Parent/Guardian 2	Parent/Guardian 1 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