fraser academy

ASTHMA PLAN 2022-2023

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

Check all that apply:

- ☐ colds/flu
- ☐ pollen
- ☐ chemicals/scents
- ☐ strong emotions
- ☐ high intensity exercise
- ☐ cold air
- ☐ dust
- ☐ mould
- ☐ animals
- ☐ smoke
- ☐ other (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 your child required **urgent or emergency care** for asthma in the past 2 years? ☐ Yes ☐ No

How **often** does your child experience asthma symptoms ? ______ times per ______

How many days did your child miss school **last year** due to their asthma? ______

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

If Yes, what are the allergen(s)? ______

Asthma Medications

Medications at Home

Please list the medications your child uses for their asthma or allergies (if applicable) **at home**:

Medication name and dosage	How much?	When is it taken?

Medications at School

Please list the asthma and allergy medications your child may need to use **at school**.

Your child will need to **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.

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 at school, please provide them as well.

Reliever medications (eg. ventolin/salbutamol)	Instructions	Location (e.g. backpack)	Spacer
			☐
		5th Floor Backup	☐

Other asthma medication(s) at school	Instructions	Location (e.g. backpack, 5th floor)

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

Exercise-Induced Asthma

Does exercise / intense physical activity trigger your child's asthma? ☐ Yes ☐ No

If yes, please describe the steps they should follow **prior** to physical activity:

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ASTHMA FIRST AID PLAN

Student

Step 1: If the student is experiencing asthma symptoms:

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

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

Yes: student can slowly return to normal activity

No: **call for a first aid attendant** to follow the first aid plan (Steps 2 / 3)

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

- Have the student administer another ____ puffs of their reliever inhaler
- Additional instructions:
- 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 2 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