



# Asthma Forms 2020-2021

Please fill in the following forms if your child has asthma and requires medication (i.e. puffer) while at school. Please return these forms to the school the first week of September along with 2 puffers, one to be kept with the student and one to be kept in the office.

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION  
FOR ASTHMA – PHYSICIAN and/or NURSE PRACTITIONER FORM**

To Be Completed by Attending Physician and/or Nurse Practitioner When the School Is First Informed  
of the Condition and if Information Changes

(Please Print or Type)

**Demographic Information**

Student's Name: \_\_\_\_\_ Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

OEN: \_\_\_\_\_

**Description of asthma**

The following triggers are likely to make the student's asthma symptoms worse:

- Animals     Chalk Dust     Colds/viral infections     Strong Smells
- Exercise: (A **reliever medication** should be available to use 10-15 minutes *before* exercise)
- Weather Conditions: (please describe which weather conditions): \_\_\_\_\_
- Allergies (please specify): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

Symptoms: The following symptoms suggest the onset of the student's asthma or worsening of asthma:

- chest tightness     coughing     shortness of breath     wheezing
- Other (please specify): \_\_\_\_\_

**Medical Certification**

This is to certify that \_\_\_\_\_ has asthma and may be given a Reliever Inhaler in the event of an asthma episode.

- Salbutamol (Ventolin, Airomir): 1 puff    2 puffs    1-2 puffs
- Terbutaline (Bricanyl):            1 puff    2 puffs    1-2 puffs
- Other: \_\_\_\_\_ 1 puff    2 puffs    1-2 puffs

Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION  
FOR ASTHMA – PARENT/GURADIAN/ADULT STUDENT FORM**

To Be Completed by Parent/Guardian/Adult Student Annually  
(Please Print or Type)

**Demographic Information**

Student's Name: \_\_\_\_\_ Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Administration of Medication**

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not trained medical personnel. However, I authorize the administration of a Reliever Inhaler, as prescribed by the attending physician and/or nurse practitioner, in the event that I /my child, \_\_\_\_\_ experiences an asthma episode on school property or during a school or school board sponsored event.

Parent/Guardian/Adult Student Name: \_\_\_\_\_

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

Principal Signature: \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Self-Administration of Medication**

I consent to have my child \_\_\_\_\_ carry a Reliever Inhaler on her/his person.

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

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

Principal Signature: \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

I consent to have my child \_\_\_\_\_ self-administer the Reliever Inhaler prescribed by the attending physician and/or nurse practitioner.

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

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

Principal Signature: \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Consent to the Development of an Individual Asthma Plan of Care**

I consent to the development of an Individual Asthma Plan of Care for myself/my child \_\_\_\_\_  
\_\_\_\_\_. This plan will outline the emergency steps that shall be taken if myself/my child experiences an asthma  
emergency on school property or during a school or school board sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my/my child's protection  
and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers, occasional teachers,  
itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

Parent/Guardian/Adult Student Name: \_\_\_\_\_

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

Principal's Signature: \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_ Year \_\_\_\_\_

**Posting of Photographs**

I consent to the posting of photographs of myself/my child \_\_\_\_\_  
and of medical information (Individual Asthma Plan of Care) in the following locations:

- Classroom       Lunchroom       Staff Room       Other  \_\_\_\_\_  
Office       School Bus       Resource Room       \_\_\_\_\_

Parent/Guardian/Adult Student Name: \_\_\_\_\_

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

Principal's Signature: \_\_\_\_\_ Date: Month \_\_\_\_\_ Day \_\_\_\_ Year .



| INDIVIDUAL ASTHMA PLAN OF CARE |                     |                      |
|--------------------------------|---------------------|----------------------|
| STUDENT INFORMATION            |                     |                      |
| Student Name _____             | Date Of Birth _____ | Student Colour Photo |
| Ontario Ed. # _____            | Age _____           |                      |
| Grade _____                    | Teacher(s) _____    |                      |

| EMERGENCY CONTACTS (LIST IN PRIORITY) |              |               |                 |
|---------------------------------------|--------------|---------------|-----------------|
| NAME                                  | RELATIONSHIP | DAYTIME PHONE | ALTERNATE PHONE |
| 1.                                    |              |               |                 |
| 2.                                    |              |               |                 |
| 3.                                    |              |               |                 |

| KNOWN ASTHMA TRIGGERS   |  |                                     |  |                                 |
|---|--|-------------------------------------|--|---------------------------------|
| CHECK (✓) ALL THOSE THAT APPLY  |  |                                     |  |                                 |
| <input type="checkbox"/> Colds/Flu/Illness  | <input type="checkbox"/> Change In Weather     | <input type="checkbox"/> Pet Dander | <input type="checkbox"/> Strong Smells |                                 |
| <input type="checkbox"/> Smoke (e.g., tobacco, fire, cannabis, second-hand smoke) | <input type="checkbox"/> Mould                 | <input type="checkbox"/> Dust       | <input type="checkbox"/> Cold Weather  | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Physical Activity/Exercise                               | <input type="checkbox"/> Other (Specify) _____ |                                     |  |                                 |
| <input type="checkbox"/> At Risk For Anaphylaxis (Specify Allergen) _____         |  |                                     |  |                                 |
| <input type="checkbox"/> Asthma Trigger Avoidance Instructions: _____<br>_____    |  |                                     |  |                                 |
| <input type="checkbox"/> Any Other Medical Condition Or Allergy? _____<br>_____   |  |                                     |  |                                 |

## DAILY/ ROUTINE ASTHMA MANAGEMENT

### 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:

Airomir  Ventolin  Bricanyl  Other (Specify) \_\_\_\_\_

Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible**.

Reliever inhaler is kept:

With \_\_\_\_\_ – location: \_\_\_\_\_ Other Location: \_\_\_\_\_

In locker # \_\_\_\_\_ Locker Combination: \_\_\_\_\_

Student **will carry** their reliever inhaler **at all times** including during recess, gym, outdoor and off-site activities.

Reliever inhaler is kept in the student's:

Pocket

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): \_\_\_\_\_ Other Location: \_\_\_\_\_

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

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

## EMERGENCY PROCEDURES

### IF ANY OF THE FOLLOWING OCCUR:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)

(\* Student may also be restless, irritable and/or quiet.)

### **TAKE ACTION:**

**STEP 1:** Immediately use fast-acting reliever inhaler (usually a blue inhaler). Use a spacer if provided.

**STEP 2:** Check symptoms. Only return to normal activity when all symptoms are gone.

If symptoms get worse or do not improve within 10 minutes, this is an **EMERGENCY!**

Follow steps below.

### IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin or neck or chest sucked in with each breath

(\*Student may also be anxious, restless, and/or quiet.)

### **THIS IS AN EMERGENCY:**

**STEP 1: IMMEDIATELY USE ANY FAST-ACTING RELIEVER (USUALLY A BLUE INHALER).  
USE A SPACER IF PROVIDED.**

Call 9-1-1 for an ambulance. Follow 9-1-1 communication protocol with emergency responders.

**STEP 2:** If symptoms continue, use reliever inhaler every 5-15 minutes until medical attention arrives.

While waiting for medical help to arrive:

- ✓ Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction).
- ✓ Do not have the student breathe into a bag.
- ✓ Stay calm, reassure the student and stay by his/her side.
- ✓ Notify parent(s)/guardian(s) or emergency contact.

\*\*\*Refer to Appendix L for the Policy Manual – Students - Miscellaneous – S.M.12 Asthma

## HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

**Healthcare provider may include:** Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: \_\_\_\_\_

Profession/Role: \_\_\_\_\_

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

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

\*This information may remain on file if there are no changes to the student's medical condition.

## AUTHORIZATION/PLAN REVIEW

### INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

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

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Other Individuals To Be Contacted Regarding Plan Of Care:

Before-School Program  Yes  No \_\_\_\_\_

After-School Program  Yes  No \_\_\_\_\_

School Bus Driver/Route # (If Applicable) \_\_\_\_\_

Other: \_\_\_\_\_

**We the Parents/Guardians/Adult Student request the posting of this Individual Plan of Care, including recent colour photo in the:**

Staff Room \_\_\_\_\_ Elementary Homeroom Classroom \_\_\_\_\_ School Main Office \_\_\_\_\_

**We, the Parents/Guardians/Adult Student request the sharing of information on signs and symptoms of Asthma with students in the classroom. Yes \_\_\_\_\_ No \_\_\_\_\_**

**This plan remains in effect for the 20\_\_ — 20\_\_ school year without change and will be reviewed on or before:** \_\_\_\_\_. (It is the adult student/parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s): \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

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

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



