Appendix 4: Individual Student Asthma Management Plan Form

Visit www.on.lung.ca to access an AODA-compliant version or to order free copies of The Lung Association - Ontario's *Individual Student Asthma Management Plan* form.

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 _____ (Name of Medication) in the dose of _____. (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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