Plan of Care: Asthma

If changes to any part of this plan are required, please complete a new form (including consent and authorization signatures) and share with all involved.

IDENTIFICATION

Student name:	School name:	
Date of birth (mm/dd/yyyy):	Health card number:	MedicAlert® number: ☐ N/A

Does the student carry an Emergency Health Services (EHS) Special Patient Protocol card? ☐ Yes ☐ No

If yes, what is the Special Patient Protocol card number:

Allergies:	Medical diagnosis(es):

TRIGGERS

Place Photo Here

Identify asthma triggers for the student as they apply to school:

☐ Colds/viral infections
☐ Exercise/physical activity
☐ Scents
☐ Anxiety/stress
☐ Weather/temperature changes/seasonal
☐ Allergies; please specify:
☐ Other; please specify:

Is the student aware of their diagnosis? ☐ Yes ☐ No

Does the student experience fears and/or anxiety related to their health care needs/medical diagnosis?

☐ Yes ☐ No *If yes*, please describe helpful coaching/support/management strategies:

Describe strategies that help the student stay calm in the event of an asthma flare-up:

Medications required during school hours: ☐ N/A 1. 2. 3.	Location where medication is stored at the school (refer to the Regional Centre of Education's policy): 1. 2. 3.

Does the student have any activity restrictions while at school? ☐ Yes ☐ No *If yes,* please describe:

Bus Driver Name(s) and Bus Number(s)	
Morning bus: ☐ N/A	Afternoon bus: ☐ N/A

The bus driver(s) and/or school designated person(s) providing transportation have been notified by the school principal (or designate) of student's medical diagnosis.

☐ Yes ☐ N/A

Emergency Contacts—*Please prioritize (1, 2, 3) in the order the calls are to be placed.*

1. Name: Relationship:	Home phone: Work phone: Cell phone:	Email:
2. Name: Relationship:	Home phone: Work phone: Cell phone:	Email:
3. Name: Relationship:	Home phone: Work phone: Cell phone:	Email:

Non-Emergency Preferred Method of Communication

☐ Phone call
☐ Text
☐ Other; please specify:
☐ Communication book/agenda
☐ Email

Additional information:

Designated School Staff with Training (*to be completed by school staff*)

1.	4.
2.	5.
3.	6.

DEFINITION

Asthma is a chronic (long-term) disease affecting the airways (breathing passages) in the lungs. People with asthma have extra sensitive airways, and various things can trigger their airways to become red, swollen, constricted, and/or filled with mucous, making it difficult to breathe.

STRATEGIES TO MANAGE TRIGGERS AT SCHOOL

Identify asthma triggers for the student as they apply to school:

☐ Colds/viral infections
Describe strategies to manage triggers at school:

☐ Exercise/physical activity
Describe strategies to manage triggers at school:

☐ Weather/temperature changes/seasonal
Describe strategies to manage triggers at school:

☐ Scents
Describe strategies to manage triggers at school:

☐ Anxiety/stress
Describe strategies to manage triggers at school:

☐ Allergies; please specify:

Describe strategies to manage triggers at school:

☐ Other; please specify:

Describe strategies to manage triggers at school:

EXERCISE PROCEDURE

If exercise/physical activity triggers the student's asthma, list steps in the order the student should follow before gym class, recess, or other physical activity:

Reliever medication is required before physical activity: ☐ Yes ☐ No

SYMPTOMS

Asthma flare-up symptoms include (but are not limited to):

- Frequent cough especially after or during exercise
- Wheezing (a high pitched musical sound when breathing), which may get worse with exertion
- Chest tightness
- Faster, harder breathing
- Persistent cough after coming from playing outside or with temperature change

Severe asthma flare-up/"asthma attack" symptoms include (but are not limited to):

- Indrawing (the skin is "sucked in" with each breath at the neck and/or around the collar bone)
- Shortness of breath at rest or when talking (can only say three to five words between breaths)
- Tripod stance (leaning over with hands on wall, knees, or table)
- Worsening of symptoms despite use of additional doses of reliever medication

Typical symptoms for the student—check those that apply:

☐ Coughing ☐ Shortness of breath ☐ Wheezing ☐ Chest tightness

☐ Other; please specify:

RELIEVER MEDICATION

Identify the prescribed reliever medication (medication used during a flare-up):

☐ Ventolin/Salbutamol ☐ Bricanyl ☐ Other; please specify:

Identify the device to be used with the reliever medication, if applicable:

☐ Spacer with a facemask ☐ Diskus

☐ Spacer with a mouthpiece ☐ Turbuhaler ☐ Aerosol compressor

If staff are to administer the medication, or support the student while they self-administer, provide step-by-step instructions for use:

Location of the reliever medication in the school:

Note: Reliever medications are considered emergency medications and therefore must be stored in safe, unlocked, and accessible locations. (Refer to your Regional Centre for Education's policy.)

COMMUNICATION

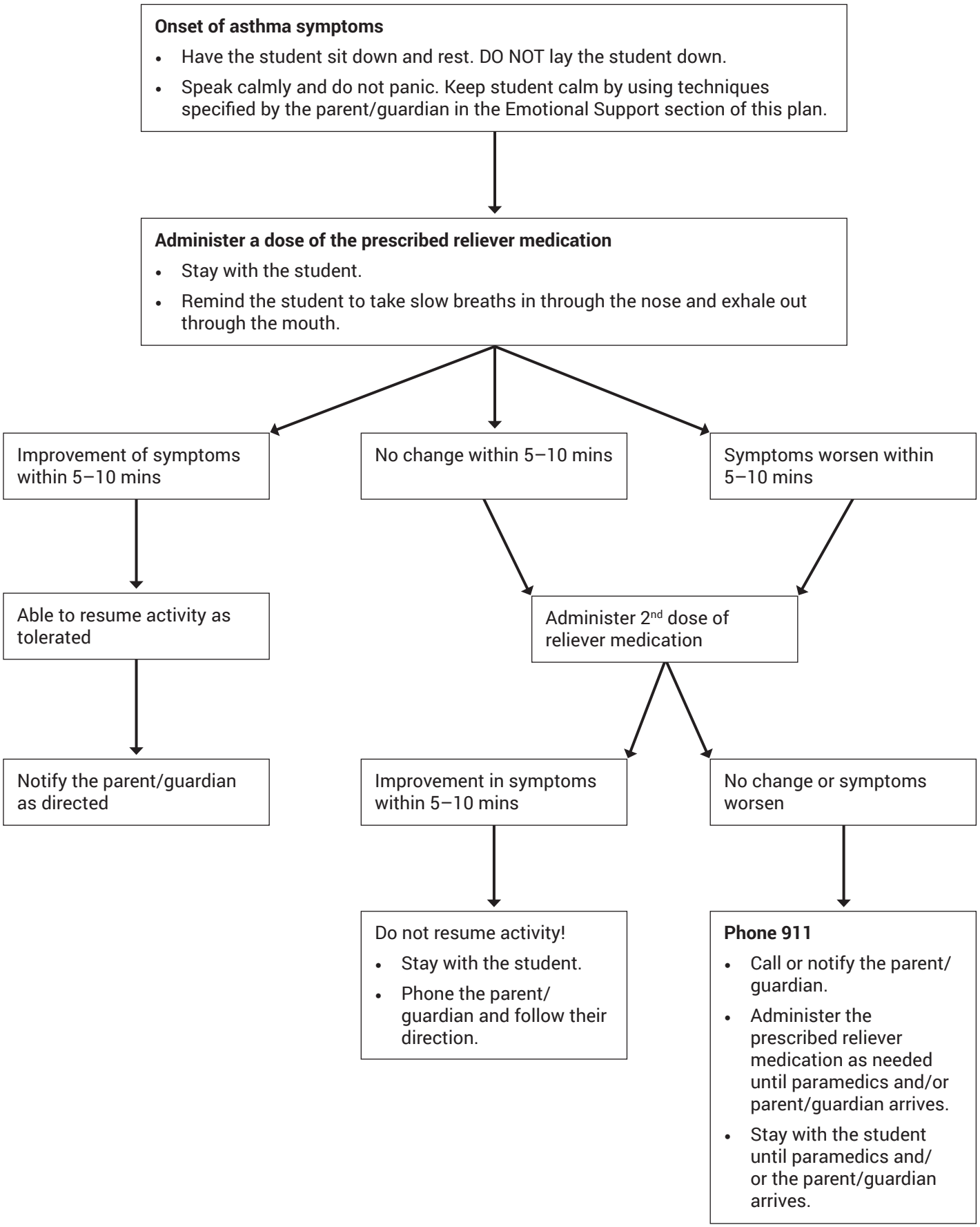
Notify parent/guardian (check all that apply):

☐ If symptoms persist 5–10 minutes after receiving one dose of reliever medicine (e.g., Ventolin/Salbutamol)

☐ Each time the reliever medicine (e.g., Ventolin/Salbutamol) is administered in school

☐ Other; please specify:

EMERGENCY ACTION PLAN



PARENT/GUARDIAN (STUDENT, IF APPROPRIATE) CONSENT

Release of Plan of Care Information

I agree with the plan of care outlined in this document. I am aware that 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 notify my child's principal if there is a need to change or cancel this plan during the school year. If I wish to change or cancel this plan, I will do so in writing.

I authorize school staff to share information from this plan for purposes related to the education, health, and safety of my child. This may include

- displaying my child's picture in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of my child's medical condition
- placing a copy of this plan in appropriate locations in the school and storing an electronic copy in the Nova Scotia Student Information System
- communicating with school bus drivers or other designated persons who may be transporting my child
- any other sharing of information that may be necessary to protect the health and safety of my child

✍ _____ _____

Parent/Guardian Signature mm/dd/yyyy

✍ _____ _____

Student Signature (if appropriate) mm/dd/yyyy

AUTHORIZATIONS

My name below indicates that I have reviewed and am in agreement with the information contained in this Plan of Care and when needed have been in contact with the authorized prescriber and/or other regulated health care provider(s) for clarification and verification as indicated below.

✍ _____ _____

Regulated Health Care Professional Signature mm/dd/yyyy

_____ _____

Print Name Print Designation

As applicable, name of authorized prescriber and/or regulated health care provider and date of contact:

_____

✍ _____ _____

Principal Signature mm/dd/yyyy

_____

Print Name

The signature of the SHP Nurse below indicates involvement in the development of this plan.

✍ _____ _____

School Health Partnership (SHP) Nurse Signature (when applicable) mm/dd/yyyy

_____

Print Name

PLAN OF CARE EFFECTIVE DATE

This plan is effective as of _____ (mm/dd/yyyy). *Note: Plans of care must be reviewed, updated, and signed annually.*