Toronto District School Board

INDIVIDUAL STUDENT ASTHMA MANAGEMENT PLAN

To be completed by the Principal/Designate with Parent/Guardian or student 16 years or older, if appropriate (The information contained herein will be stored in a secure location in the school office)

Student Name *(Surname, First Name)*	D.O.B *(dd/mmm/yyyy)*	Gender ☐M ☐F ☐ Other	Student #
Address	Postal Code	Health Care #	
Student Home Phone #	Medic Alert I.D Yes ☐ No ☐	Teacher	Grade#
Parent/Guardian (1)	Home Phone #	Alternate Phone #	
Parent/Guardian (2)	Home Phone #	Alternate Phone #	
Emergency Contact Person		Phone #	

Place Student Photo Here (Optional)

Use of Reliever Medication and Controller Medication at School and During Out of School Activities (including sporting events and over-night excursions)

A. ☐ Student **will carry and/or self-administer** his/her reliever/controller medication (this includes during recess, gym, outdoor and off-site activities and field trips) as prescribed.

Reliever/controller medication is kept in the student's:
☐ Pocket ☐ Backpack/fanny pack ☐ Case/pouch
☐ Other (specify):_____

B. ☐ Student requires assistance to administer reliever/controller medication (see Asthma Management operational procedure, Section 6.2 Special Considerations for Student with Additional Needs.)
Please explain:

_____

_____

_____

☐ Back-up reliever inhaler is available and will be kept in the main office.

The supervising teachers will have the back-up reliever inhaler during sporting events, excursions and all other out of school activities to be used in emergency situations.

Each time staff administers prescribed asthma medication information must be recorded on the Student Log of Administered Medication form.

Please indicate type of prescribed reliever inhaler:

☐ Salbutamol (e.g., Ventolin) ☐ Airomir ☐Ventolin ☐ Bricanyl

☐ Other (specify): _____

Please indicate type of prescribed controller medication:

☐ Flovent ☐ Advair ☐Qvar ☐ Pulmicort

☐ Other (specify): _____

Personal information on this form is collected under the authority of the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, *Personal Health Information Protection Act, 2014, S.O. 2004, Chapter 3 Schedule A* and *Bill 20, Ryan's Law* (*Ensuring Asthma Friendly Schools*), *2015.*

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)

Use of Reliever Medication in the Case of an Emergency

Staff may administer reliever inhaler medication to a student in the event that there is reason to believe that the student is experiencing worsening or asthma exacerbation, even when there is no preauthorized written consent from the parent/guardian or student, as appropriate.

Staff shall inform the parent/guardian/ in an emergency situation. If the student's asthma worsens, staff will call 911.

Staff must record this information must be recorded on the Student Log of Administered Medication form.

Student Background Information

Asthma Triggers:

☐ Colds/flu/illness	☐ Physical activity/exercise	☐ Pet dander
☐ Cigarette smoke	☐ Pollen	☐ Mould
☐ Dust	☐ Cold weather	☐ Strong smells
☐ Allergies (specify): _____	☐ Anaphylaxis (specify): _____	☐ Other (specify): _____

Asthma trigger avoidance instructions: _____

_____

_____

Other Pertinent Medical Information, e.g., allergies, anaphylaxis, etc.:

_____

_____

_____

To be signed by the Parent/Guardian or student who is 16 years or older

I give consent for (student's name) _____
to **carry and/or self-administer** his/her prescribed medications and inhalers to manage asthma while at school and during school-related activities. (Students who are 16 years of age or older do not require the permission of their parents/guardians to carry their asthma medication.)

I give consent to have asthma medication administered to my child as per Section 6.2 of the Asthma Management operational procedure and/or in the event of an emergency situation.

I will provide the medication(s) in the original container with the expiration date labelled by my pharmacist. The Administration of Prescribed Medications Form will be completed and submitted to the Principal/Designate.

I give consent for the contents of this Individual Student Management Plan to be shared with staff and others who are in direct contact on a regular basis with my child.

I will inform the school of any change in medication or inhaler.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Student Name (16 years of age or older) _____

Signature: _____ Date: _____

To be completed by Health Care Professional – Optional

To be completed by health care professional (e.g., Pharmacist, Respiratory Therapist, Certified Asthma Educator, Certified Respiratory Educator, Nurse, Medical Doctor, or other clinician working within their scope of practice):

Health Care Provider's Name: _____
(please print)

Profession: _____

Comments: _____

_____

_____

_____

_____

Signature: _____

Date: _____