PREVALENT MEDICAL CONDITION ASTHMA
PLAN OF CARE

STUDENT INFORMATION		Student Photo
Student Name:		
Student wears Medical-Alert Bracelet YES NO		
Date of Birth	Age:	
Teacher	Grade:	☐ **I consent to publicly displaying this photo.**

EMERGENCY CONTACTS in ORDER

Name	Relationship	Phone #
1.		
2.		
3.		
4.		

KNOWN LIFE-THREATENING TRIGGERS (check all that apply)

☐ FOOD to be AVOIDED

LIST:

☐
☐
☐
☐

SAFETY MEASURES:

☐ INSECT STINGS

LIST:

☐
☐
☐
☐

SAFETY MEASURES:

- ☐ Avoid areas where stinging insects next or congregate.
- ☐ Report, remove or destroy nests
- ☐ Remove or cover trash bins
- ☐ Keep food indoors

☐ OTHER

LIST:

☐
☐
☐
☐

SAFETY MEASURES:

STUDENT NAME:

EMERGENCY RESCUE

Has medication been prescribed to manage this condition? Yes No
Has emergency recovery medication been prescribed? Yes No

If yes, this plan must be shared with your physician and the following section (appendix A) must be completed by a physician.

☐ **NCCSA AUTHORIZATION OF PROVISION OF ORAL/TOPICAL Prescription MEDICATION**

Does the student have any other Prevalent Medical Conditions for which there is a Plan of Care?

Yes No

If Yes, check all that apply:

- ☐ Anaphylaxis
- ☐ Diabetes
- ☐ Epilepsy/ Seizures
- ☐ Concussion
- ☐ General: _____

DAILY MANAGEMENT

A reliever inhaler is a fast acting medication that is used when someone is having asthma symptoms.
It is encouraged that your child carry the reliever inhaler.
The reliever inhaler will be found:

- ☐ On the child in a fanny pack etc
- ☐ In the child's backpack
- ☐ In the office
  - ☐ Location:
- ☐ In the classroom
  - ☐ Location

The reliever inhaler should be used:

- ☐ When having troubles breathing (coughing, wheezing)
- ☐ Other: Explain:

Instructions:

- ☐ Dose:
- ☐ Frequency:
- ☐ Spacer Chamber Provided? Yes No

STUDENT NAME:

NCCSA EMERGENCY PROCEDURES FOR ASTHMA

MILD ASTHMA

SYMPTOMS	RESPONSE
□ continuous coughing □ complaints of chest tightness □ difficulty breathing □ wheezing (not always present (Above symptoms may also be accompanied by: restlessness, irritability, tiredness)	☐ Administer reliever inhaler. ☐ If there is no improvement in 5 to 10 minutes **THIS IS AN EMERGENCY** ☐ Stay calm. Remain with the child. ☐ Tell the child to breathe slowly & deeply ☐ Notify parent of episode ☐ Child can resume normal activities once feeling better

ASTHMA EMERGENCY

SYMPTOMS	RESPONSE
ANY of the following symptoms indicate an emergency! □ unable to catch breath □ difficulty speaking a few words □ lips or nail bed blue or gray □ breathing is difficult & fast (greater than 25 breaths per minute)	☐ **CALL 911** ☐ Give reliever inhaler immediately & continue to use reliever inhaler every ____ minutes until help arrives ☐ Stay calm. Remain with the child ☐ Tell child to breathe slowly & deeply ☐ Contact Parent

INDIVIDUALS with whom THIS PLAN OF CARE WILL BE SHARED

- ☐ **I/we authorize the principal to share the Plan of Care with school staff who are in direct contact with my child.**
- ☐ **I/we are aware that the school will share this Plan of Care with:**
  - ☐ **Niagara Children's Centre**
  - ☐ **Nursing (if applicable)**
  - ☐ **Transportation Provider**

This plan of care remains in effect for the _____ School Year and will be reviewed within the first 30 days of a new school year
If at that time, there are no changes to the student medical history, this information may remain on file.
It is the responsibility of parents to notify the principal if there is a need to change this plan during the school year.

Parent Signature:	Date:
Student Signature:	Date:
Principal Signature:	Date:

Appendix A

niagara children's centre school Weaving education and therapy together for student success.
AUTHORIZATION OF PROVISION OF ORAL/TOPICAL PRESCRIPTION MEDICATION
TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME		
BIRTHDATE		**GRADE**
ADDRESS		**PHONE NUMBER**
PARENT NAME		

HEALTH CARE PROVIDER INFORMATION
Please review the NCCSA Plan of Care with your healthcare provider.

Provider Name	Provider Address and Phone Number	☐ Physician ☐ Nurse Practitioner
Special Instructions from Health Care Provider		

Name of Medication	
DATE	
Date prescribed	
Dosage to be provided each time	
Times dosage to be provided	
Method of administration	
Possible side effects	
Storage and safekeeping s	

PARENT/GUARDIAN APPROVAL
I hereby request and give permission to NCCSA to provide Oral/topical prescription medication to my child according to NCCSA procedures and the instructions provided.
I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Health Care Provider **Optional** UNLESS medication is rescue medication.		
Signature of Parent/Guardian		DATE: