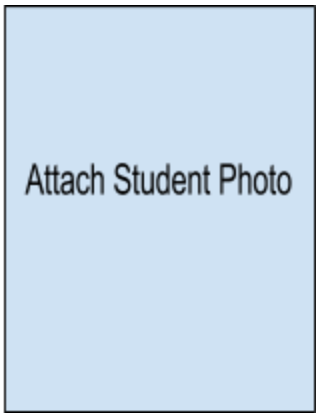
UCC
UPPER CANADA COLLEGE

Asthma Management Plan

STUDENT NAME: _____ **DOB:** _____



Personal Asthma Triggers

(check all that apply):

- ☐ Animal dander
- ☐ Respiratory infections
- ☐ Pollen
- ☐ Mould
- ☐ Dust mites
- ☐ Physical activity/exercise
- ☐ Fumes / odors
- ☐ Temperature changes
- ☐ Smoke
- ☐ Anaphylaxis (specify allergy):

_____

- ☐ Other: _____

Early warning signs & symptoms of an asthma attack for this student:

- ☐ Persistent or troublesome cough
- ☐ Wheezing
- ☐ Asthma symptoms during or following exercise
- ☐ Complaints of chest tightness or shortness of breath
- ☐ Having to use reliever inhaler more frequently
- ☐ Feeling weak or tired
- ☐ Other _____

Emergency Contact Information

Name	Relationship	Phone	Cell Phone

Asthma Management Plan

1. As soon as early signs and symptoms of an asthma attack are identified, have the student self-administer his own inhaler as prescribed below. The student may require assistance administering his inhaler.

Medication	Dose and Frequency	When to use

2. Remain with student and have another staff member contact nurse and/or parent/guardian
3. Reassure student and continue to monitor closely, encourage student to stay calm
4. Accompany student to the Health Centre when he is able to do so following every incident
5. If 911 is called, accompany or have another staff member accompany the student in the ambulance and remain with the student until a parent/guardian arrives to the hospital.

Call 911 and report a worsening asthma attack if:

- Reliever medication is not helping relieve symptoms
- Wheezing when student breathes both in and out
- Difficulty talking and/or walking
- Struggling to breathe
- Inability to stop coughing
- Tight neck and chest muscles
- Lips or fingernails are blue
- Pale or sweaty skin

If the student requires to be transported to hospital by ambulance, notify the Critical Incident Report Team (CIRT).

Physician's Approval

I support the above Asthma Management Plan for this patient.

Print Name _____ Signature : _____

Phone _____ Date: _____

Additional Notes:_____

_____

Parent/Guardian Consent

We agree that, _____
(Student Name)

☐ can **carry** his prescribed medications and delivery devices to manage asthma while at school and during school-related activities.

☐ can **self-administer** his prescribed medications and delivery devices to manage asthma at school and during school-related activities.

☐ **requires assistance** with administering his prescribed medications and delivery devices to manage asthma while at school and during school-related activities.

☐ We will inform the College of any change in medication and delivery device. The medications **cannot** be beyond the expiration.

The undersigned, being the parent or guardian of the student, hereby authorizes the administration of inhalers and/or other prescribed medications and subsequent medical care to this student in the event of an asthma attack (respiratory issues).

It is understood that, should the student require emergency treatment outside the school, every effort will be made to contact the parent or guardian.

Print Name _____ Relationship _____

Signature _____ Date _____

Print Name _____ Relationship _____

Signature _____ Date _____

Student Consent

I, _____ understand and agree to this Asthma Care Plan.

Signature _____ Date _____