



YORK CATHOLIC DISTRICT SCHOOL BOARD

ASTHMA PLAN OF CARE & CONSENT FORM

RIM	
Board Form	Board Form No.
Student Services	S.40-206
Classification	Retention
STU 45	C + 1
Approved Date	Revision Date
	June 2025

ASTHMA Plan of Care		
STUDENT INFORMATION		
Date Created _____	Bus Route/# _____	Insert Photo Student Photo (optional)
Student Name _____	Date Of Birth _____	
Age _____	School _____	
Grade _____	Teacher(s) _____	
Any other medical condition or allergy? _____	MedicAlert® ID ☐ Yes ☐ No	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN ASTHMA TRIGGERS			
CHECK (✓) ALL THOSE THAT APPLY			
☐ Colds/Flu/Illness	☐ Weather (cold/hot/humid)	☐ Pets/Animals	☐ Strong Smells
☐ Vape/Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)	☐ Mould	☐ Dust	☐ Pollen
☐ Physical Activity/Exercise	☐ Strong Emotions (e.g., anxiety, stress, laughing, crying, etc.)		☐ Other (Specify)
☐ At Risk For Anaphylaxis (Specify Allergen)			
☐ Asthma Trigger Avoidance Instructions: _____			

DAILY/ ROUTINE ASTHMA MANAGEMENT

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 of _____ in the dose of _____ as needed.

(Name of Medication)

(Number of Puffs)

Spacer (valved holding chamber) provided? ☐ Yes ☐ No

Place a (✓) check mark beside the type of reliever inhaler that the student uses:

☐ Airomir/Salbutamol ☐ Ventolin/Albuterol ☐ Bricanyl/Terbutaline ☐ Other (Specify) _____

☐ Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible** (in accordance to [Ryan's Law](#))

Reliever inhaler is kept:

☐ With _____ Location: _____ Other Location: _____

☐ In locker # _____ Locker Combination: _____

☐ Student **will carry** their reliever inhaler **at all times** including in the classroom, outside the classroom (e.g., library, cafeteria/lunchroom, gym) and off-site (e.g., field trips/excursions)

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): _____ Other Location: _____

☐ In locker #: _____ Locker Combination: _____

CONTROLLER MEDICATION USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITIES

Controller medications are taken regularly every day to control asthma. Usually, they are taken in the morning and at night, so generally not taken at 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)

Note: Ask parents/guardians for the child's **Asthma Action Plan** and go over it with them. Download the Action Plan here or visit <https://lunghealth.ca/resource-library/>

EMERGENCY PROCEDURES

FOR MANAGEMENT

IF ANY OF THE FOLLOWING OCCUR:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)

(* Student may also be restless, irritable and/or quiet.)

TAKE ACTION:

STEP 1: Immediately use fast-acting reliever inhaler (usually a blue inhaler). Use a spacer if provided.

STEP 2: Check symptoms. Only return to normal activity when all symptoms are gone.

If symptoms get worse or do not improve within 10 minutes, this is an **EMERGENCY!**

Follow steps below.

FOR AN EMERGENCY

IF ANY OF THE FOLLOWING OCCUR:

- Reliever puffer **lasts less** than 3 hours
- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin on neck or chest sucked in with each breath

(*Student may also be anxious, restless, and/or quiet.)

EMERGENCY ACTION:

**STEP 1: IMMEDIATELY USE ANY FAST-ACTING RELIEVER (USUALLY A BLUE INHALER).
USE A SPACER IF PROVIDED.**

Call 9-1-1 for an ambulance. Follow 9-1-1 communication protocol with emergency responders.

STEP 2: If symptoms continue, use reliever inhaler every 5-15 minutes until medical attention arrives.

While waiting for medical help to arrive:

- ✓ Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction).
- ✓ Do not have the student breathe into a bag.
- ✓ Stay calm, reassure the student and stay by their side.
- ✓ Notify parent(s)/guardian(s) or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

* This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other Individuals To Be Contacted Regarding Plan Of Care:

Before-School Program ☐ Yes ☐ No _____

After-School Program ☐ Yes ☐ No _____

School Bus Driver/Route # (If Applicable) _____

Other: _____

This plan remains in effect for the 20__— 20__ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s): _____ Date: _____

Signature

Student: _____ Date: _____

Signature

Principal: _____ Date: _____

Signature

Consent Form (Self-Administer and/or Employee Administer)

To Carry and Administer Medication for a Prevalent Medical Condition

CONSENT FORM

TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____ (specify type of medication) by an employee of the _____ (school board) as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT

Class/Teacher: _____

Student's Name: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

Signature of Student: _____

Date: _____

(if 18 years of age or older)

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____ to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT

Student's Name: _____

Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

Signature of Student: _____

Date: _____

(if 18 years of age or older)

Name of Physician: _____

Physician Phone #: _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Personal information on this form is collected under the authority of the *Education Act* and s. 28(2) of the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA). It will be used to develop and administer the student's emergency Plan of Care and may be shared with authorized YCDSB staff and emergency responders as necessary. Questions about this collection should be directed to the Principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the _____
(School Board) through the posting of photographs and medical information of my child
(Plan of Care/Emergency Procedures) in the following key locations:

- | | | | |
|------------------------------------|-------------------------------------|------------------------------------|--------------------------------|
| ☐ classroom | ☐ staffroom | ☐ lunchroom | ☐ other |
| ☐ office | ☐ school bus | ☐ gym | |

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (☐) all applicable boxes

- | | |
|--|---|
| ☐ Food service providers | ☐ Child care providers |
| ☐ Board approved transportation carriers | ☐ Other _____ |
| ☐ School volunteers in regular direct contact with my child | |

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

Signature of Principal: _____ Date: _____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR.