

District School Board of Niagara  
**ADMINISTRATIVE PROCEDURE**

**APPENDIX A (AP 3-31)**  
Page 1 of 1



## STUDENT ASTHMA MANAGEMENT PLAN

(To be completed by parent/guardian)

STUDENT \_\_\_\_\_ AGE \_\_\_\_\_  
 TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_

EMERGENCY CONTACT (List in priority of contact)			
Name	Relationship	Daytime Phone	Alternate Phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**KNOWN ASTHMA TRIGGERS**

- Colds/flu  
  Physical activity  
  Hot or cold weather  
  Strong smells  
  Pets  
  Pollen  
  Allergies (specify): \_\_\_\_\_  
 Anaphylaxis (specify allergy): \_\_\_\_\_  
  Other (specify): \_\_\_\_\_

**RELIEVER INHALER (FAST-ACTING, USUALLY BLUE)**



Use reliever inhaler \_\_\_\_\_ in the dose of \_\_\_\_\_ Spacer provided?  Yes  No  
(name of medicine) (number of puffs)

- Reliever inhaler is used to:
- Relieve symptoms being experienced (see "MANAGING ASTHMA ATTACKS" below)
  - Other (please explain) \_\_\_\_\_
- Student requires assistance to access and use reliever inhaler. Make sure it is readily accessible by teacher/supervisor.  
 Student will carry their inhaler at all times including outdoor activities and field trips.

We agree \_\_\_\_\_ is responsible for carrying his/her inhaler at all times (including recess, gym, outdoor and off-site activities).  
(insert student name)

Parent/guardian signature: \_\_\_\_\_ Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MANAGING ASTHMA ATTACKS**

MILD ASTHMA ATTACK	
<p><b>If ANY</b> of the following occur:</p> <ul style="list-style-type: none"> <li>Continuous coughing</li> <li>Trouble breathing</li> <li>Chest tightness</li> <li>Wheezing (whistling sound in chest)</li> </ul> <p>Student may also be restless, irritable and/or very tired</p>	<div style="text-align: center; font-size: 2em;">➔</div> <p>Step 1: <b>Immediately</b> use fast-acting reliever inhaler (usually a blue inhaler).</p> <p>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 <b>emergency</b> – follow steps below</p>
ASTHMA EMERGENCY	
<p><b>If ANY</b> of the following occur:</p> <ul style="list-style-type: none"> <li>Breathing is difficult and fast</li> <li>Cannot speak in full sentences</li> <li>Lips or nail beds are blue or gray</li> <li>Skin on neck or chest sucked in with each breath</li> </ul> <p>Student may also be anxious, restless and/or very tired</p>	<div style="text-align: center; font-size: 2em;">➔</div> <p>Step 1: <b>Immediately</b> use fast-acting reliever inhaler (usually a blue inhaler). <b>CALL 911</b> for an ambulance. If possible, stay with person.</p> <p>Step 2: If symptoms continue, use reliever inhaler every 5-15 minutes until medical help arrives</p>
<p><b>While waiting for medical help to arrive:</b></p> <ul style="list-style-type: none"> <li>✓ Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction)</li> <li>✓ Stay calm, reassure the student and stay by his/her side</li> <li>✓ Notify parent/guardian or emergency contact</li> </ul>	

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**APPENDIX B (AP 3-31)**  
 Page 1 of 1  
 Copied from AP 3-12 (Appendix B)

**AUTHORIZATION OF ADMINISTRATION OF ORAL/TOPICAL MEDICATION**

**TO BE COMPLETED BY PARENT/GUARDIAN**

<b>Name of Student</b>			
<b>Birthdate</b>		<b>Grade</b>	
<b>Address</b>			
<b>Postal Code</b>		<b>Telephone</b>	
<b>Parent's/Guardian's Name</b>			
<b>Business Address</b>			
<b>Postal Code</b>		<b>Telephone</b>	

**PARENT/GUARDIAN APPROVAL**

I hereby request and give permission to {Name of School} \_\_\_\_\_ to administer Oral/topical medication to my child according to School Board procedures and the instructions of the Physician. I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

<b>Condition of Patient for which Oral/Topical Medication is Necessary</b>	
<b>Name of Medication</b>	
<b>Dosage or Amount to be Given Each Time</b>	· As Indicated on Prescription Label
<b>What Time(s) Dosage to be Given</b>	· As Indicated on Prescription Label
<b>Method of Administration (with Food?)</b>	
<b>Possible Side Effects</b>	
<b>Storage and Safekeeping Requirements for Medication</b>	
<b>Prescribing Physician's Name {Please Print}</b>	
<b>Office Address and Telephone Number</b>	

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_