Appendix A

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR ASTHMA – PHYSICIAN and/or NURSE PRACTITIONER FORM

To Be Completed by Attending Physician and/or Nurse Practitioner When the School Is First Informed of the Condition and if Information Changes
(Please Print or Type)

Demographic Information

Student's Name: _____ Birthdate: Month _____ Day_____ Year_____

OEN: _____

Description of asthma

The following triggers are likely to make the student's asthma symptoms worse:

☐ Animals ☐ Chalk Dust ☐ Colds/viral infections ☐ Strong Smells
☐ Exercise: (A **reliever medication** should be available to use 10-15 minutes *before* exercise)
☐ Weather Conditions: (please describe which weather conditions): _____
☐ Allergies (please specify): _____
☐ Other (please specify): _____

Symptoms: The following symptoms suggest the onset of the student's asthma or worsening of asthma:

☐ chest tightness ☐ coughing ☐ shortness of breath ☐ wheezing

☐ Other (please specify): _____

Medical Certification

This is to certify that _____ has asthma and may be given a Reliever Inhaler in the event of an asthma episode.

- Salbutamol (Ventolin, Airomir): 1 puff 2 puffs 1-2 puffs
- Terbutaline (Bricanyl): 1 puff 2 puffs 1-2 puffs
- Other: _____ 1 puff 2 puffs 1-2 puffs

Doctor's Name: _____ Telephone: _____

Doctor's Signature: _____ Date: Month _____ Day _____ Year _____

SS-06-58-INT (Copy to Documentation File of OSR and Student Medical File)

Appendix B

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR ASTHMA – PARENT/GURADIAN/ADULT STUDENT FORM

To Be Completed by Parent/Guardian/Adult Student Annually
(Please Print or Type)

Demographic Information

Student's Name: _____ Birthdate: Month_____ Day ____ Year _____

Administration of Medication

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not trained medical personnel. However, I authorize the administration of a Reliever Inhaler, as prescribed by the attending physician and/or nurse practitioner, in the event that I /my child, _____ experiences an asthma episode on school property or during a school or school board sponsored event.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Principal Signature: _____ Date: Month _____ Day ____ Year _____

Self-Administration of Medication

I consent to have my child _____ carry a Reliever Inhaler on her/his person.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Principal Signature: _____ Date: Month _____ Day _____ Year _____

I consent to have my child _____ self-administer the Reliever Inhaler prescribed by the attending physician and/or nurse practitioner.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Principal Signature: _____ Date: Month _____ Day _____ Year_____

I, _____ consent to carry a Reliever Inhaler on my person and to self-administer
(Student's name)
the Reliever Inhaler prescribed by my physician and/or nurse practitioner.

Adult Student Name: _____

Adult Student Signature: _____

Principal Signature: _____

Date: _____/_____/_____
Month Day Year

Posting of Photographs

I consent to the posting of photographs of myself/my child _____

and of medical information (Individual Asthma Plan of Care) in the following locations:

Classroom ☐ Lunchroom ☐ Staff Room ☐ Other ☐ _____

Office ☐ School Bus ☐ Resource Room ☐ _____

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Principal's Signature: _____ Date: Month _____ Day _____ Year .

Consent to the Development of an Individual Asthma Plan of Care

I consent to the development of an Individual Asthma Plan of Care for myself/my child _____ _____. This plan will outline the emergency steps that shall be taken if myself/my child experiences an asthma emergency on school property or during a school or school board sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my/my child's protection and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Principal's Signature: _____ Date: Month _____ Day _____ Year _____

SS-06-58-INT (Copy to Documentation File of OSR and Student Medical File

Appendix C

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

INDIVIDUAL ASTHMA PLAN OF CARE

STUDENT INFORMATION

Student Name _____	Date Of Birth _____	Student Colour Photo
Ontario Ed. # _____	Age _____	
Grade _____	Teacher(s) _____	

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	❒ Change In Weather	❒ Pet Dander	❒ Strong Smells	
❒ Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)	❒ Mould	❒ Dust	❒ Cold Weather	❒ Pollen
❒ Physical Activity/Exercise	❒ Other (Specify)_____			

❒ At Risk For Anaphylaxis (Specify Allergen) _____

❒ Asthma Trigger Avoidance Instructions:_____

_____

❒ Any Other Medical Condition Or Allergy? _____

_____

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 reliever inhaler _____ in the dose of _____
(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 ❒ Ventolin ❒ Bricanyl ❒Other (Specify) _____

❒ Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible**.

Reliever inhaler is kept:
- ❒ With _____ – location: _____ Other Location: _____
- ❒ In locker # _____Locker Combination: _____

❒ Student **will carry** their reliever inhaler **at all times** including during recess, gym, outdoor and off-site activities.

Reliever inhaler is kept in the student's:
- ❒ Pocket
- ❒ 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: _____

CONTROLLER MEDICATION USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITES

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)

EMERGENCY PROCEDURES

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.

IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin or neck or chest sucked in with each breath

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

THIS IS AN EMERGENCY:

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 his/her side.
- ✓ Notify parent(s)/guardian(s) or emergency contact.

***Refer to Appendix L for the Policy Manual – Students - Miscellaneous – S.M.12 Asthma

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: _____

We the Parents/Guardians/Adult Student request the posting of this Individual Plan of Care, including recent colour photo in the:

Staff Room _____ Elementary Homeroom Classroom _____ School Main Office _____

We, the Parents/Guardians/Adult Student request the sharing of information on signs and symptoms of Asthma with students in the classroom. Yes _____ No _____

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____. (It is the adult student/ 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

Appendix J

Hamilton-Wentworth Catholic District School Board
Believing, Achieving, Serving

CONSENT TO THE DISCLOSURE, SHARING AND EXCHANGE OF VERBAL INFORMATION, TRANSMITTAL OR EXAMINATION OF A RECORD

I (We) _____
(PRINT FULL NAME)

of _____
(ADDRESS)

Hereby consent to the disclosure, sharing and exchange of verbal information or transmittal to, or examination by:

_____
(Name of Person, Agency, or Institution)

of _____
(Identify Material: Clinical record, Report, File, Verbal Disclosure, etc.)

compiled/prepared by: _____
(Name or Names as Appropriate)

in respect of _____
(Name of Student and School)

for the purpose of _____

Nature of the information to be released _____

_____.

_____ _____
(Signature) **(Witness)***

_____
(If other than Student, state relationship to Student)

Dated the _____ day of _____, 20___.

This Consent is valid for the remainder of the school year, from the date of signature, that is, The _____ day of _____, 20____. Unless previously withdrawn in writing.

* ***In the absence of other convenient witnesses, the professional may serve as witness.***

Please complete both sides…

Allergy/Anaphylaxis Management Plan
Waiver (cont.)

STUDENT: _____ SCHOOL: _____

	Father's Signature:	Mother's Signature:	Guardian's Signature:
☐ I/We have decided that one Reliever/Inhaler will be provided for my/our child _____ while s/he is in attendance at the school, and it will be stored: ☐ On the student or ☐ At a main access point in the school	(Date)	(Date)	(Date)
☐ I/We have decided that my/our child _____, will not carry an Reliever/Inhaler her/his person while s/he is in attendance at school. I/We understand that this will impede access to medication during an asthmatic reaction, and may limit access to medication during a fire/ bomb threat/ lock-down, or while riding a bus.	(Date)	(Date)	(Date)
☐ I/We have decided that my/our child _____, will not sit in a designated seat close to the bus driver while riding the school bus.	(Date)	(Date)	(Date)
☐ I/We have decided that my/our child _____, _____-_____ _____	(Date)	(Date)	(Date)

Routing: Original - Principal. Copy - Parent/Guardian. Copy - Superintendent of Education