



ST. GABRIEL CATHOLIC ELEMENTARY SCHOOL

1361 Barton St. E.

Winona, Ontario

L8E 5L1

TEL: (905)523-2468 FAX: (905)643-6620

"CELEBRATING FAITH, FAMILY AND LEARNING"



Mrs. T. Ferrie
Superintendent

Mr. B. Condari
Principal

Mr. D. Pereira
Vice-Principal

Re: Medical Alert Information for Students with Asthma

Dear Parent(s)/Guardian(s),

The Hamilton-Wentworth Catholic District School Board has revised the HWCDSB School Health Procedures: Asthma Plan as of September 2018. As primary caregivers of their child, parents are expected to be active participants in supporting the management of their child's medical condition(s) while the child is in school.

The following forms are being sent home to ensure the management plans at school are current and comply with these new procedures.

1. Appendix A: Authorization for Administration of Medication for Asthma – Physician or Nurse Practitioner Form (**when school is first informed or if information has changed**)
2. Appendix B: Authorization for Administration of Medication for Asthma – Parent/Guardian Form (to be completed by parent(s)/guardian(s) annually)
3. Appendix C: Individual Asthma Plan of Care *New form as of September 2018* (to be completed by parent(s)/guardian(s) annually)
4. Provide a minimum of one (1) up-to-date Reliever Inhaler properly marked with their child's name and the medication's expiry date to be stored in the school's office, along with one (1) up-to-date Reliever Inhaler properly marked with their child's name and the medication expiry date to be kept on the child.
5. A waiver form must be signed if you decide that your child:
 - a) will not carry a reliever/inhaler on their person at all times throughout the day at school and while attending out of school learning experiences.
 - b) will not sit in a designated seat close to the bus driver while riding the bus.

Please return the following completed package with signatures as soon as possible. If you have any questions or concerns, please contact Mr. Menegazzo at 905-523-2468.

Thank you for your continued support.

Sincerely,

Mr. B. Condari
Principal

Mr. R. Menegazzo
Special Education Resource Teacher

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)

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 ____
Ontario Health Card Number: _____

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 _____



INDIVIDUAL ASTHMA PLAN OF CARE

STUDENT INFORMATION

Student Name _____

Date Of Birth _____

Ontario Ed. # _____

Age _____

Student Colour Photo

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

<input type="checkbox"/> Colds/Flu/Illness	<input type="checkbox"/> Change In Weather	<input type="checkbox"/> Pet Dander	<input type="checkbox"/> Strong Smells
<input type="checkbox"/> Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)	<input type="checkbox"/> Mould	<input type="checkbox"/> Dust	<input type="checkbox"/> Cold Weather
<input type="checkbox"/> Pollen	<input type="checkbox"/> Other (Specify) _____		
<input type="checkbox"/> Physical Activity/Exercise			
<input type="checkbox"/> At Risk For Anaphylaxis (Specify Allergen) _____			
<input type="checkbox"/> Asthma Trigger Avoidance Instructions: _____			
<input type="checkbox"/> 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

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)

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 K 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



ST. GABRIEL CATHOLIC ELEMENTARY SCHOOL

1361 Barton St. E.
Winona, Ontario
L8E 5L1

TEL: (905)523-2468 FAX: (905)643-6620
"CELEBRATING FAITH, FAMILY AND LEARNING"



Mrs. I. Fortino
Superintendent

Mr. B. Condari
Principal

Mr. D. Pereira
Vice-Principal

**Asthma Management Plan
Waiver**

Dear Parents/Guardians of: _____:

As you are aware, the Asthma Management Plan of the Hamilton-Wentworth Catholic District School Board requires that:

- each student who has been identified as being at risk of having an asthmatic reaction carry a Reliever/Inhaler on her/his person while attending school and when involved in out-of-school learning experiences;
- please note that parents/guardians are advised that if they authorize their child to NOT carry an Reliever/Inhaler on his/her person at all times, their Reliever/Inhaler may not be accessible or available;
- the child, who is at risk to have an asthmatic reaction carry one Reliever/Inhaler on her/his person while at school, on the school bus or while participating in school sponsored activities away from the *main school campus*;
- the child, who is at risk to have an asthmatic reaction sits in a designated seat close to the bus driver while riding the school bus.

It is my understanding that:

- you do not agree to have your child carry one Reliever/Inhaler on her/his person;
- you do not wish to have your child sit in a designated seat on the school bus close to the bus driver.

I would ask you, therefore, to complete the form attached to this letter waiving one or more of the above requirements and return it to me in the enclosed envelope as soon as possible.



Principal

Please complete both sides...

Allergy/Anaphylaxis Management Plan Waiver (cont.)

STUDENT: _____

SCHOOL: _____

	Father's Signature:	Mother's Signature:	Guardian's Signature:
<input type="checkbox"/> 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: <input type="checkbox"/> On the student or <input type="checkbox"/> At a main access point in the school	(Date)	(Date)	(Date)
<input type="checkbox"/> I/We have decided that my/our child _____, will <u>not</u> 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)
<input type="checkbox"/> I/We have decided that my/our child _____ will <u>not</u> sit in a designated seat close to the bus driver while riding the school bus.	(Date)	(Date)	(Date)
<input type="checkbox"/> I/We have decided that my/our child _____ _____ _____	(Date)	(Date)	(Date)

Routing: Original - Principal. Copy - Parent/Guardian. Copy - Superintendent of Education
Page 2 of 2