Place Student Photo Here

APPENDIX A

Niagara Catholic Student Asthma Management Plan of Care

Name of Student: _____ D.O.B.: _____ (MM/DD/YEAR)

Name of Teacher: _____ Grade: _____

Emergency Contact Information (List in priority of contact)			
Name	**Relationship**	**Daytime Phone**	**Alternate Phone**
1.			
2.			
3.			

Known Asthma Triggers

☐ Air Quality ☐ Allergies (specify)_____ ☐ Cold/flu ☐ Physical Activities ☐ Pollen

☐ Anaphylaxis (specify allergy)_____ ☐ Other (specify) _____

RELIEVER INHALER

_____has been diagnosed with asthma and has been prescribed a reliever inhaler.
(Name of student)

Instructions/Dosage: _____ **Expiry Date:** _____

Name of Physician: _____ **Phone No.** _____

Signature of Physician: _____ **Date:** _____

PARENT/GUARDIANCONSENT

I, _____ confirm that my child _____
(Print Name) (Print Name of Student)

is responsible and has permission to carry their reliever inhaler at all times including outdoor activities and field trips.

Please Check One:

☐ Student will be responsible to carry and administer their own reliever inhaler.

☐ Student requires assistance to use their reliever inhaler. Make sure it is readily accessibility by teacher/supervisor.

Signature of Parent/Guardian: _____ Date: _____