APPENDIX A

Niagara Catholic Student Asthma Management Plan of Care

Place Student Photo Here

Personal information on this form is being collected under the authority of the Education Act, in accordance with the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Heath Information protection Act (PHIPA). The purpose of this collection is to develop a personalized student Asthma Management Plan of Care. Questions about this collection should be directed to the Superintendent of Education, Safe and Accepting Schools, Niagara Catholic District School Board, 427 Rice Road, Welland, ON L3C 7C1 Telephone (905) 735-0240.

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:**