GREATER SASKATOON CATHOLIC SCHOOLS

Asthma Support Care Plan

Student Name: **Date:**

Current School Year:

Parent/Guardian: **Parent Home Phone:**

Parent/Guardian: **Parent Home Phone:**

Other Emergency Contact:

Asthma

☐ Student is able to manage asthma independently
☐ Student requires adult supervision to manage asthma

Symptoms

Observable symptoms possible emergency, side effect of medication:

☐ Rescue inhaler is only working for less than 3 hours
☐ Difficulty speaking
☐ Hard time breathing after a rest
☐ Lips/nails turn blue
☐ Consistent coughing or wheezing
☐ Chest tightness
☐ Increased mucus production

Triggers

☐ Seasonal
☐ Smoke
☐ Dust
☐ Pets & Animals
☐ Allergies (please list): _____
☐ Cleaning products
☐ Perfumes/essential oils, etc.
☐ Viral Infections
☐ Molds

Action

1. Call emergency contacts listed on top of form.
2. Remain with student to ensure symptoms subside.
3. Ask student to sit and calm.
4. Take rescue inhaler. Location of puffer: _____
5. Give medication if ordered by a parent or healthcare provider. Name of medication:_____ Dosage: _____

Additional Information:

Critical Response Plan

1. **Call 911 and parent/guardian.**
2. **If student stops breathing, administer CPR.**

Authorization	
Parent/Guardian Name (please print):	Physician Name (please print):
Parent/Guardian Signature: _____	Physician Signature: _____
Relationship to child:	Physician Clinic Name and Address:
Date:	Date:
Designated and trained staff:	