



# MEDICAL ALERT INFO & CARE PLAN (Asthma)

## D. PROCEDURES TO DEAL WITH A PROBLEM

1. Check medications & administration (section C)
2. Ensure that bronchodilator medication is available and administered. Have an adult stay with the student.
3. Repeat treatment in 10 minutes if symptoms persist.
4. The attack is **SEVERE** if:
  - a) Two bronchodilator treatments have not helped, **OR**
  - b) The student has difficulty speaking, moving; or is turning blue, pale or sweating; or requests a doctor, ambulance or to go to hospital - **IMMEDIATELY arrange for transportation to hospital - CALL 911.**
5. Notify parent/guardian.

## D. TO BE COMPLETED BY THE PARENT / GUARDIAN

Initials

- \_\_\_\_\_ I am aware of Board Policy and Regulation on the Treatment of Students with Medical Problems.
- \_\_\_\_\_ I agree that the above information is correct.
- \_\_\_\_\_ If changes occur I will contact the school and provide revised instructions.
- \_\_\_\_\_ I agree that if medication is required I will supply it to the school in the original container with my child's name and the pharmacist's directions for use, including dosage.
- \_\_\_\_\_ I am aware that no medication will be administered until this form is completed and returned.
- \_\_\_\_\_ I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- \_\_\_\_\_ I am aware that staff working with my child may need to know of my child's condition and of the medication required.
- \_\_\_\_\_ I am aware I am required to update this information each September, or as it changes.

I authorize and request the administration of the above medication from \_\_\_\_\_ to \_\_\_\_\_.

I will provide the medication in the original container with expiration date, labelled by a pharmacist.

\_\_\_\_\_ *Signature of Parent / Guardian* \_\_\_\_\_ *Date*

## E. TO BE COMPLETED BY THE PRINCIPAL OR DESIGNATE

Staff designated to supervise/administer medication

Alternate(s)

Location of Medication in the School

\_\_\_\_\_ *Name of Principal or Designate (please print)*

\_\_\_\_\_ *Signature of Principal or Designate*

\_\_\_\_\_ *Date*

## F. TRAINING DOCUMENTATION

| Date of Training / Review | Name of Trainer |
|---------------------------|-----------------|
|                           |                 |
|                           |                 |
|                           |                 |