Authorization for Administration of Reliever Medication & Asthma Standard Health Care Plan (SHCP)

(To be completed by parent)

School name: _____ **School year**: _____

Student information

Name: _____ **Birthdate**: _____/_____/_____
Year Month Day

Address: _____

MHSC # (6 digit):_____ PHIN # (9 digit): _____

Parent information

Parent: _____ Daytime phone(s) _____

Parent: _____ Daytime phone(s) _____

Emergency contact: _____ Daytime phone(s)____ _____

Medical information

Name	Dose	Medication device
☐ Salbutamol (e.g. Ventolin®, Airomir)	☐ 1 puff	☐ Metered dose inhaler (MDI) 
☐ Symbicort®	☐ 2 puffs	☐ MDI & spacer device with mouthpiece 
☐ Other_____ School to contact URIS nurse if parent selected "other".	☐ 1 or 2 puffs	☐ MDI & spacer device with mask  ☐ Turbuhaler  ☐ Other

Name of prescribing physician: _____

Trigger(s) for asthma (if known): _____

Location of reliever medication: _____

As per school policy, the student shall carry urgently required medication on their person.

Parent authorization

I understand that:

- Authorization to administer medication is renewed annually with student registration or upon a change in medication.
- The pharmacy label must be on the medication device.
- The parent is responsible for replacing expired medication as well as the removal and disposal of expired medication.

I hereby request and authorize the school to administer the medication named above to my child as outlined in the attached Asthma Standard Health Care Plan.

Parent signature: _____ **Date:** _____

School administrator signature: _____ **Date:** _____

Manitoba

Asthma Standard Health Care Plan

The Asthma SHCP is based on the clinical practice guidelines developed by the Unified Referral and Intake System (URIS) in consultation with Children's Allergy and Asthma Education Centre (CAAEC) at Health Sciences Centre. These clinical practice guidelines are available on the URIS website. Unified Referral and Intake System (URIS) | Manitoba Education and Early Childhood Learning (gov.mb.ca)

IF YOU SEE THIS: ➡	**DO THIS:**
Symptoms of asthma • Coughing • Wheezing • Chest tightness • Shortness of breath • Increase in rate of breathing while at rest	1. Remove the child from triggers of asthma. 2. Have the child sit down. 3. Ensure the child takes reliever medication (usually blue cap or bottom). 4. Encourage slow deep breathing. 5. Monitor the child for improvement of asthma symptoms. 6. If reliever medication has been given and asthma symptoms do not improve in 5-10 minutes, contact parent/guardian. *Reliever medication can be repeated once at this time. If the child is not well enough to remain at the community program, the parent/guardian should come and pick them up.* 7. If any of the emergency situations occur (see list below), call 911/EMS.
Emergency situations • Skin pulling in under the ribs • Skin being sucked in at the ribs or throat • Greyish/bluish color in lips and nail beds • Inability to speak in full sentences • Shoulders held high, tight neck muscles • Cannot stop coughing • Difficulty walking	1. Activate 911/EMS. *Delegate this task to another person. Do not leave the child alone.* 2. Continue to give reliever medication as prescribed every five minutes. 3. Notify the parent/guardian. 4. Stay with the child until EMS personnel arrive.

Unified Referral and Intake System (URIS) Group B Application

In accordance with Section 15 of *The Personal Health Information Act* (PHIA), the purpose of this form is to identify the child's health care intervention(s) and apply for URIS Group B support which includes the development of a health care plan and training of community program staff by a registered nurse. If you have questions about the information requested on this form, you may contact the community program.

Section I – Community program information (to be completed by the community program)

Type of community program (please √)	Name of community program: Angus McKay School
✓ School ❑ Licensed childcare ❑ Respite ❑ Recreation program	Contact person: Ashlee Laurin-Clark
	Phone: 204-661-2378 Fax: 204-668-9283
	Email: alaurinclark@retsd.mb.ca
	Address (**location where service is to be delivered)**: Street: 850 Woodvale Street City/Town: Winnipeg POSTAL CODE: R2K 2G8

Section II - Child information

Last Name **First Name** **Birthdate**

month (print) D D Y Y Y Y

Also Known As

Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program.

❑ **Life-threatening allergy (and child is prescribed an EpiPen)**

Does the child bring an EpiPen to the community program? ☐ YES ☐ NO

❑ **Asthma (administration of medication by inhalation)**

Does the child bring asthma medication (puffer) to the community program? ☐ YES ☐ NO

Can the child take the asthma medication (puffer) on his/her own? ☐ YES ☐ NO

❑ **Seizure disorder**

What type of seizure(s) does the child have? _____

Does the child require administration of rescue medication (e.g., sublingual lorazepam)? ☐ YES ☐ NO

❑ **Diabetes**

What type of diabetes does the child have? ☐ Type 1 ☐ Type 2

Does the child require blood glucose monitoring at the community program? ☐ YES ☐ NO

Does the child require assistance with blood glucose monitoring? ☐ YES ☐ NO

Does the child have low blood sugar emergencies that require a response? ☐ YES ☐ NO

❑ **Cardiac condition** where the child requires a specialized emergency response at the community program.

What type of cardiac condition has the child been diagnosed with? _____

❑ **Bleeding Disorder** (e.g., von Willebrand disease, hemophilia)

What type of bleeding disorder has the child been diagnosed with? _____

❑ **Steroid Dependence** (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease)

What type of steroid dependence has the child been diagnosed with? _____

❑ **Osteogenesis Imperfecta (brittle bone disease)**

❑ **Gastrostomy Feeding Care**

Does the child require gastrostomy tube feeding at the community program? ☐ YES ☐ NO

Does the child require administration of medication via the gastrostomy tube at the community program? ☐ YES ☐ NO

❑ **Ostomy Care**

Does the child require the ostomy pouch to be emptied at the community program? ☐ YES ☐ NO

Does the child require the established appliance to be changed at the community program? ☐ YES ☐ NO

Does the child require assistance with ostomy care at the community program? ☐ YES ☐ NO

❑ **Clean Intermittent Catheterization (IMC)**

Does the child require assistance with IMC at the community program? ☐ YES ☐ NO

❑ **Pre-set Oxygen**

Does the child require pre-set oxygen at the community program? ☐ YES ☐ NO

Does the child bring oxygen equipment to the community program? ☐ YES ☐ NO

❑ **Suctioning (oral and/or nasal)**

Does the child require oral and/or nasal suctioning at the community program? ☐ YES ☐ NO

Does the child bring suctioning equipment to the community program? ☐ YES ☐ NO

Section III - Authorization for the Release of Medical Information

I authorize the Community Program, the Unified Referral and Intake System Provincial Office, and the nursing provider serving the community program, all of whom may be providing services and/or supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's physician(s), if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for _____.
(child's name)

I also authorize the Unified Referral and Intake System Provincial Office to include my child's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that my child's personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the parent/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

If I have any questions about the use of the information provided on this form, I may contact the community program directly.

_____ _____
Parent/Legal guardian signature Date

_____ _____ _____
Mailing Address Postal Code Phone number