Schools Asthma Management Plan

Students Name ___________________________________________________
Age ____________ Date of Birth ____/____/____  Class ________________
Teacher’s Name _______________________________________________________________
Parent’s/Guardian’s Names ___________________________________________________
Phone: Home (     ) ____________________ Work (     ) ____________________________
Emergency Contact: Name ___________________ Phone ___________________
Doctor’s Name _____________________________
      Phone (BH)____________________(Mobile/Pager) ________________
Ambulance Subscriber  Yes/No (Subscriber No)_____Medicare No ____________

Schools Emergency Action Plan

This section to be completed by the student’s Doctor in consultation with their parent/guardian.

1. What are the student’s usual symptoms of asthma (✓)?
   - Wheezing  [ ]
   - Tightness in chest  [ ]
   - Coughing  [ ]
   - Difficulty in breathing  [ ]
   Other (please describe) _____________________________________________________________________________
   _____________________________________________________________________________

2. What are the student’s signs / symptoms of worsening asthma?
   Please describe _____________________________________________________________________________

3. Please (✓) preferred Emergency Action Plan
   ❑ Victorian Schools Asthma Policy for Emergency Treatment of an Asthma Attack
     (Section 4.5.7.8 of the Department of Education Schools of the Future Reference Guide).
     1. Sit the student down and remain calm to reassure the student.
     2. Without delay give 4 puffs of a Reliever inhaler (Ventolin, Respolin or Bricanyl), using a spacer
        (spacer technique – 1 puff/take 4 breaths from spacer, repeat until 4 puffs have been given).
     3. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per step 2.
     4. If no improvement, call an ambulance (dial 000) immediately and state that “a student is
        having an asthma attack”.
     5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.
   ❑ Student’s Emergency Treatment (if different from above)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage (eg 2 puffs)</th>
<th>Method (eg puffer and spacer)</th>
<th>How often (eg every 4 mins)</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
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Additional comments:
Is medication usually required at School?

- [ ] No
- [ ] Yes (if yes, please provide the following information)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Does the student need pre-exercise Medication?

- [ ] No
- [ ] Yes (if yes, please provide the following information)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Under what circumstances? (e.g., cross country)</th>
</tr>
</thead>
<tbody>
<tr>
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Does the student require Assistance / Supervision from staff while taking Medication?

<table>
<thead>
<tr>
<th>Instructions</th>
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Important

- Please notify any changes in writing
- A more detailed asthma management plan will be required for overnight school excursions and camps.
- Other relevant information eg. trigger factors, side effects from medication, etc.

____________________________________________________________________________________________

____________________________________________________________________________________________

For further information about the Victorian Schools Asthma Policy and asthma management please contact Asthma Victoria on (03) 9326 7088 or Toll Free 1800 645 130

Declaration

In the event of an asthma attack at school, I agree to my son/daughter receiving the treatment described above. I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parents/Guardian's Signature: _____________________________ Date ___/___/___

Doctor's Comments (if any)

____________________________________________________________________________________________

____________________________________________________________________________________________

Doctor's Signature: _____________________________ Date ___/___/___