FORM 8 - ASTHMA MANAGEMENT & EMERGENCY RESPONSE PLAN

STUDENT DETAILS

SCHOOL:	YEAR: FORM:	INSERT PHOTO HERE
NAME:	DATE OF BIRTH:	
ADDRESS:	GENDER:	
FAMILY CONTACT DETAILS	TEACHER:	
NAME:	**MEDICAL DETAILS**	
ADDRESS:	DOCTOR 1:	
RELATIONSHIP TO STUDENT:	DOCTOR 2:	TELEPHONE:
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE:	
NAME:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE. YES ☐ NO ☐	
ADDRESS: RELATIONSHIP TO STUDENT:	DO YOU HAVE AMBULANCE COVER? YES ☐ NO ☐ **IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.**	
TELEPHONE: (W) (H) (M)	**STUDENT HAS A MEDICALERT BRACELET/PENDANT** YES ☐ NO ☐ IF YES PROVIDE DETAILS:	

SECTION A – ASTHMA MANAGEMENT – TO BE COMPLETED BY PARENT/CARER

KNOWN TRIGGER(S):
DUST ☐ **POLLEN** ☐ **SMOKE** ☐ **EXERCISE** ☐ **ANIMAL FUR** ☐ **COMMON COLD** ☐
OTHER: _____

DAILY MANAGEMENT PLANNING (IF REQUIRED)

SECTION B – MANAGEMENT INSTRUCTIONS IN THE EVENT OF AN ASTHMA ATTACK

STEPS	INSTRUCTIONS
STEP 1	SIT THE STUDENT UPRIGHT, PROVIDE REASSURANCE, AND REMAIN CALM. REMAIN WITH THE STUDENT.
STEP 2	GIVE 4 PUFFS OF BLUE RELIEVER INHALER. USE SPACER IF AVAILABLE. USE ONE PUFF AT A TIME AND ASK THE STUDENT TO TAKE 4 BREATHS AFTER EACH PUFF.
STEP 3	WAIT 4 MINUTES. IF THERE IS NO IMPROVEMENT GIVE ANOTHER 4 PUFFS.
STEP 4	**EMERGENCY INSTRUCTIONS** **IF LITTLE OR NO IMPROVEMENT OCCURS:** **a) CALL AN AMBULANCE IMMEDIATELY (DIAL 000).** **b) CALL PARENT/CARER.** **c) KEEP GIVING 4 PUFFS OF BLUE RELIEVER INHALER EVERY 4 MINUTES, UNTIL THE AMBULANCE ARRIVES.** **d) GO WITH THE STUDENT IN THE AMBULANCE IF HIS/HER PARENTS/CARERS HAVE NOT ARRIVED WHEN THE AMBULANCE IS READY TO LEAVE FOR HOSPITAL.**

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE:_____
DATE: / /

NAME: SCHOOL: DOB:

SECTION C: MEDICATION INFORMATION (IF APPLICABLE)

	INSTRUCTIONS					
	RELIEVER		PREVENTER		SYMPTOM CONTROLLER	
NAME OF MEDICATION						
EXPIRY DATE						
DOSE/FREQUENCY – MAY BE AS PER THE PHARMACIST'S LABEL						
DURATION (DATES)	FROM : TO:		FROM : TO:		FROM : TO:	
ADMINISTRATION (TICK APPROPRIATE BOX)	BY SELF REQUIRES ASSISTANCE	☐ ☐	BY SELF REQUIRES ASSISTANCE	☐ ☐	BY SELF REQUIRES ASSISTANCE	☐ ☐
STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES)	STORED AT SCHOOL KEPT AND MANAGED BY SELF REFRIGERATE KEEP OUT OF SUNLIGHT OTHER	☐ ☐ ☐ ☐ ☐	STORED AT SCHOOL KEPT AND MANAGED BY SELF REFRIGERATE KEEP OUT OF SUNLIGHT OTHER	☐ ☐ ☐ ☐ ☐	STORED AT SCHOOL KEPT AND MANAGED BY SELF REFRIGERATE KEEP OUT OF SUNLIGHT OTHER	☐ ☐ ☐ ☐ ☐

SECTION D – STAFF TRAINING REQUIREMENTS

IS SPECIFIC TRAINING FOR STAFF REQUIRED TO MANAGE YOUR CHILD'S CONDITION OR NEEDS? (YOU MAY LIKE TO DISCUSS WITH THE PRINCIPAL)
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A. FOR DAILY MANAGEMENT? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE.

B. IN AN EMERGENCY? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE.

SECTION E – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, THE PARENT/CARER AND MEDICAL PRACTITIONER (IF REQUIRED).

THE AGREEMENT AUTHORISES THE SCHOOL STAFF TO FOLLOW THE ADVICE OF THE STUDENT'S PARENT/CARER AND/OR MEDICAL PRACTITIONER AS SET OUT IN THE ASTHMA MANAGEMENT AND EMERGENCY RESPONSE PLAN. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD'S HEALTH CARE REQUIREMENTS.

PRINCIPAL: **DATE:**	**MEDICAL PRACTITIONER: (AT PRINCIPAL'S DISCRETION – SEE GUIDELINES)** **DATE:**
PARENT/CARER: **DATE:**	**REVIEW DATE:**

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____
DATE: / /

NAME:	SCHOOL:	DOB:
OFFICE USE ONLY		
IS SPECIFIC STAFF TRAINING REQUIRED? **YES** ☐ **NO** ☐		DATE:
TYPE OF TRAINING:		
NAME OF PERSON(S) TO BE TRAINED:		
PRINCIPAL SIGNATURE:		

COMPLETE ONLY RELEVANT SECTIONS AND ATTACH THE STUDENT HEALTH CARE SUMMARY FORM TO THE FRONT OF THIS DOCUMENT.