

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: PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE. YES <input type="checkbox"/> NO <input type="checkbox"/>		
NAME:	DO YOU HAVE AMBULANCE COVER? YES <input type="checkbox"/> NO <input type="checkbox"/>		
ADDRESS:	IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE		
RELATIONSHIP TO STUDENT:	STUDENT HAS A MEDICALERT BRACELET/PENDANT		
TELEPHONE: (W) (H) (M)	YES <input type="checkbox"/> NO <input type="checkbox"/> 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	<p style="color: red; margin: 0;">EMERGENCY INSTRUCTIONS</p> <p style="margin: 0;">IF LITTLE OR NO IMPROVEMENT OCCURS:</p> <ul style="list-style-type: none"> 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	<input type="checkbox"/> <input type="checkbox"/>	BY SELF REQUIRES ASSISTANCE	<input type="checkbox"/> <input type="checkbox"/>	BY SELF REQUIRES ASSISTANCE	<input type="checkbox"/> <input type="checkbox"/>
STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES))	STORED AT SCHOOL	<input type="checkbox"/>	STORED AT SCHOOL	<input type="checkbox"/>	STORED AT SCHOOL	<input type="checkbox"/>
	KEPT AND MANAGED BY SELF	<input type="checkbox"/>	KEPT AND MANAGED BY SELF	<input type="checkbox"/>	KEPT AND MANAGED BY SELF	<input type="checkbox"/>
	REFRIGERATE	<input type="checkbox"/>	REFRIGERATE	<input type="checkbox"/>	REFRIGERATE	<input type="checkbox"/>
	KEEP OUT OF SUNLIGHT	<input type="checkbox"/>	KEEP OUT OF SUNLIGHT	<input type="checkbox"/>	KEEP OUT OF SUNLIGHT	<input type="checkbox"/>
	OTHER	<input type="checkbox"/>	OTHER	<input type="checkbox"/>	OTHER	<input type="checkbox"/>

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)

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: _____
DATE: / /

PRINCIPAL SIGNATURE: _____

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.