

FORM 8 - ASTHMA MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: _____ Date of Birth: _____ Year: _____ Form: _____ Teacher: _____

Section A – Asthma management

List 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 inhale 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.

Section C – Medication Instructions (Note: Medication must be provided by parents/carers)

	Medication 1	Medication 2	Medication 3
Name of medication			
Expiry date			
Dose/frequency – may be as per the pharmacist's label			
Duration (dates)	From : To:	From : To:	
Route of administration			
Administration Tick appropriate box	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>
Storage instructions Tick appropriate box(es)	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>

Section D – Authority to Act.

This asthma management and emergency response plan authorises the school staff to follow my/our advice and/or that of our medical practitioner. It is valid for one year or until I/we advise the school of a change in my child's health care requirements.

Parent: _____	Medical Practitioner (if required): _____
Date: _____	Date: _____
Review Date: _____	

Name: Date of Birth Year: Form: Teacher:

OFFICE USE ONLY

Date received

Date uploaded on SIS:

Is specific staff training required? **Yes** **No** :

Type of training:

Training service provider:

Name of person/s to be trained:

Date of training:

When completed, please attach the student health care summary form to the front of this document and return to your child's school.
