

ASTHMA MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: _____ Date of Birth _____ Year: _____ Room: _____ 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	<p>EMERGENCY INSTRUCTIONS</p> <p>If little or no improvement occurs:</p> <p>a) Call an ambulance immediately (dial 000).</p> <p>b) Call parent/carer.</p> <p>c) Keep giving 4 puffs of blue reliever inhale every 4 minutes, until the ambulance arrives.</p> <p>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.</p>

Section C – Medication Instructions

	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 / Carer Name: _____

Signature: _____

Date: _____

Medical Practitioner (if required): _____

Signature: _____

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.