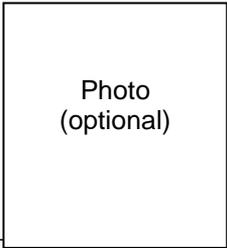




# School Asthma Management Plan

Student's Name \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Class \_\_\_\_\_  
 Teacher's Name \_\_\_\_\_  
 Parent's / Guardian's Names \_\_\_\_\_  
 Phone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Mob \_\_\_\_\_  
 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 is 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 shake a blue Reliever puffer (Ventolin, Airomir, Asmol or Bricanyl) and give 4 **separate** puffs, through 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 separate puffs, as per step 2.  
 4. Wait 4 minutes. If there is 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 )**

Medication	Dosage (eg 2 puffs)	Method (eg puffer and spacer)	How often (eg every 4 mins)

Additional comments: \_\_\_\_\_



# School Asthma Management Plan

## Usual Asthma Management Plan

1. Is medication usually required at school?  No  Yes (if yes, please provide the following information)

Medication	Dosage	How often

2. Please indicate the student's trigger factors \_\_\_\_\_

3. Does the student have any allergies?  No  Yes (if yes, please provide the following information)

\_\_\_\_\_

4. Does the student need pre-exercise medication?  No  Yes (if yes, please provide the following information)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Under what circumstances? (eg. cross country) \_\_\_\_\_

\_\_\_\_\_

5. Does the student require assistance / supervision from staff while taking medication?

No  Yes (if yes, please provide instructions)

Instructions: \_\_\_\_\_

\_\_\_\_\_

### 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 e.g. 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.

Parent's / Guardian's Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Comments (if any): \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_