FORM 8 – ASTHMA MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: **Date of birth:** **Year:** ☐ Day student ☐ Boarding student

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

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 Ventolin inhale every 4 minutes, until the ambulance arrives, d) Go with the student in the ambulance if their 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			
Time(s) or frequency			
Duration *(dates medication is required)*	Start: End:	Start: End:	Start: End:
Route of administration	☐ Oral ☐ Injection ☐ Topical ☐ Other:	☐ Oral ☐ Injection ☐ Topical ☐ Other:	☐ Oral ☐ Injection ☐ Topical ☐ Other:
Administration	☐ By self ☐ Requires assistance	☐ By self ☐ Requires assistance	☐ By self ☐ Requires assistance
Storage instructions	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*	☐ Stored at school ☐ Kept & managed by self *(Emergency medication only - EpiPen, Ventolin, etc.)*
Storage conditions	☐ Keep out of sunlight ☐ Refrigerate	☐ Keep out of sunlight ☐ Refrigerate	☐ Keep out of sunlight ☐ Refrigerate

	☐ Other:	☐ Other:	☐ Other:

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 1 year or until I/we advise the school of a change in my child's health care requirements.
Name of parent/carer: Signature of parent/carer: Date:
Name of medical practitioner: Medical practise details: Signature of medical practitioner: Date:
Review date:
When complete, please attach the student health care summary form to the front of this document and return to your child's school.

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:	