SCHOOL ASTHMA ACTION PLAN

SCHOOL LOGO
(optional)

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner).
Please tick (✓) the appropriate box and print your answers clearly in the blank spaces where indicated.
This school is collecting information on your child's asthma so we can better manage asthma while your child is in our care. The information on this Plan is confidential. All staff that care for your child will have access to this information. It will only be distributed to them to provide safe asthma management for your child at school. The school will only disclose this information to others with your consent if it is to be used elsewhere. Please contact the school at any time if you need to update this Plan or you have any questions about the management of asthma at school. If no Asthma Action Plan is provided by the parent/carer, the staff will treat asthma symptoms as outlined in the Victorian Schools Asthmas Policy: 2003.

Student's Name ______________________________

Gender M ☐ F ☐ **Age** ________ **Date of Birth** ____/____/____ **Form/Class** ________

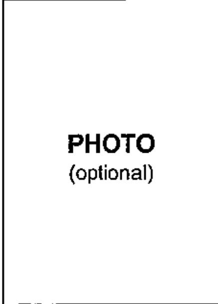
Emergency Contact (e.g. Parent/Carer) ____________________ **Relationship** ____________

Phone (H) ______________ (B/H) ______________ Mobile ______________

Doctor's Name ______________________________ Phone ______________

Ambulance Subscriber Y ☐ N ☐ Subscriber no. ______________________

Medicare No. ______________________________



USUAL ASTHMA ACTION PLAN

Usual signs of child's asthma	Worsening signs of child's asthma	What triggers the child's asthma?
	Increased signs of:	
Wheezing ________ ☐	Wheezing ________ ☐	Exercise ________ ☐
Tightness in chest ________ ☐	Tightness in chest ________ ☐	Colds/Viruses ________ ☐
Coughing ________ ☐	Coughing ________ ☐	Pollens ________ ☐
Difficulty in breathing ________ ☐	Difficulty in breathing ________ ☐	Dust ________ ☐
Difficulty speaking ________ ☐	Difficulty speaking ________ ☐	Other Triggers (please describe)
Other (please describe)	Other (please describe)	

Does your child need assistance taking their medication? Y ☐ N ☐

Asthma medication requirements usually taken at school:
(including preventers, symptom controllers, combination medication, medication before exercise)

Name of Medication	Method (e.g. puffer & spacer, turbuhaler)	When, and how much?

Is your child on regular preventer medication taken at home? Y ☐ N ☐

2004 ©

Please turn over

SCHOOL ASTHMA ACTION PLAN

Australian Government
Department of Health and Ageing

Asthma First Aid Plan

Please tick (✓) preferred First Aid Plan:

☐ **Victorian Schools Asthma Policy for Asthma First Aid**

(Section 4.5.7.8 of Department of Education and Training's Victorian Government Schools' Reference Guide.

1. Sit the student down and remain calm to reassure the student. Do not leave the student alone.
2. Without delay shake a blue reliever puffer (names include Ventolin, Airomir, Asmol or Epaq) 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.

If at any time the student's condition suddenly worsens, call an ambulance immediately.

OR

☐ **Student's Asthma First Aid Plan** (if different from above)

- Please notify me if my child regularly has asthma symptoms at school.
- Please notify me if my child has received asthma first aid.
- In the event of an asthma attack at school, I agree to my son/daughter receiving the treatment described above.
- I authorise school staff to assist my child with taking asthma medication should they require help.
- I will notify you in writing if there are any changes to these instructions.
- I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent's / Guardian's Signature: ______________________ **Date** ____/____/____

Doctor's Signature: ______________________ **Date** ____/____/____

Doctor's Provider Number: ______________________

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly Schools Program and asthma management please contact: Asthma Victoria on (03) 9326 7088 or Toll Free 1800 645 130 or visit our web site **www.asthma.org.au**

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