

SCHOOL ASTHMA ACTION PLAN



This record is to be completed by parents/carers in consultation with their child's doctor. Please tick the appropriate box and print your answers clearly in the blank spaces where indicated. The information on this Plan is confidential. All staff that care for your child will have access to this information. 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 Asthma Policy (**Section 4.5.10.3** of the Department of Education and Early Childhood Development Victorian Government Schools' Reference Guide).

STUDENT'S PERSONAL DETAILS

Student's Name _____ Gender M F

Date of Birth ___/___/___ Form/Class _____ Teacher _____

Ambulance Membership Yes No Membership No. _____

What other health management plans does this student have, if any? _____

Emergency Contact (e.g. parent/carer)

Name _____ Relationship _____

Ph: (H) _____ (W) _____ (M) _____

Doctor _____ Ph: _____

PHOTO

USUAL ASTHMA ACTION PLAN

Usual signs of student's asthma:

- Wheeze Tight Chest Cough Difficulty breathing Difficulty talking Other _____

Signs student's asthma is getting worse

- Wheeze Tight Chest Cough Difficulty breathing Difficulty talking Other _____

Student's Asthma Triggers

- Cold/flu Exercise Smoke Pollens Dust Other _____

Asthma Medication Requirements (Including relievers, preventers, symptom controllers, combination)

Name of Medication (e.g. Ventolin, Flixotide)	Method (e.g. puffer & spacer, turbuhaler)	When and how much? (e.g. 1 puff in morning and night, before exercise)

Does the student need assistance taking their medication? Yes No If yes, how? _____

Managing Exercise Induced Asthma (EIA)

If exercise is a trigger for this student they should follow these steps to prepare for exercise:

1. Take their blue reliever or doctor recommended medication 5-10 minutes before warm up. Warm up appropriately before exercise or activity and always cool down following activity and be alert for asthma symptoms after exercise.

If a student gets EIA during exercise they should:

1. Stop the exercise or activity and refer to the student's asthma first aid plan (on back page). If their symptoms reoccur, recommence treatment. **DO NOT RETURN TO THE ACTIVITY** for the rest of the day and inform the parent/carer any incident.

ASTHMA FIRST AID PLAN

Please tick preferred Asthma First Aid Plan

Victorian Schools Asthma Policy for Asthma First Aid

(Section 4.5.10.3 of the Department of Education and Early Childhood Development Victorian Government Schools' Reference Guide)

Step 1. Sit the person upright
- be calm and reassuring
- Do not leave them alone.

Step 2. Give medication
- Shake the blue reliever puffer
- Use a spacer if you have one
- Give 4 separate puffs into a spacer
- Take 4 breaths from the spacer after each puff
*You can use a Bricanyl Turbuhaler if you do not have access to a puffer and spacer
Giving blue reliever medication to someone who doesn't have asthma is unlikely to harm them

Step 3. Wait 4 minutes
- If there is no improvement, repeat steps 2.

Step 4 If there is still no improvement call emergency assistance (**DIAL 000**).
- Tell the operator the person is having an asthma attack
- Keep giving 4 puffs every 4 minutes while you wait for emergency assistance

Call emergency assistance immediately (DIAL 000) if the person's asthma suddenly becomes worse

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, 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 agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent's/Guardian's Signature: _____ Date ___/___/___

Doctor's Signature: _____ Date ___/___/___

For further information about the Victorian Schools Asthma Policy or asthma management please contact **The Asthma Foundation of Victoria** on (03) 9326 7088, toll free 1800 645 130, or visit www.asthma.org.au