

FORM 8 - ASTHMA MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: _____ Date of Birth: _____ Year: _____ Form: _____ 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 | 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 blue reliever inhale every 4 minutes, until the ambulance arrives. 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. |

Section C – Medication Instructions (Note: Medication must be provided by parents/carers)

| | 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 | By self | <input type="checkbox"/> | By self | <input type="checkbox"/> | By self | <input type="checkbox"/> |
| Tick appropriate box | Requires assistance | <input type="checkbox"/> | Requires assistance | <input type="checkbox"/> | Requires assistance | <input type="checkbox"/> |
| Storage instructions | Stored at school | <input type="checkbox"/> | Stored at school | <input type="checkbox"/> | Stored at school | <input type="checkbox"/> |
| Tick appropriate box(es) | Kept and managed by self | <input type="checkbox"/> | Kept and managed by self | <input type="checkbox"/> | Kept and managed by self | <input type="checkbox"/> |
| | Refrigerate | <input type="checkbox"/> | Refrigerate | <input type="checkbox"/> | Refrigerate | <input type="checkbox"/> |
| | Keep out of sunlight | <input type="checkbox"/> | Keep out of sunlight | <input type="checkbox"/> | Keep out of sunlight | <input type="checkbox"/> |
| | Other | <input type="checkbox"/> | Other | <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: _____ Date: _____ Review Date: _____

Medical Practitioner (if required): _____ 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.
