Student Asthma Record

EMERGENCY MEDICAL PLAN pto

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner). Parents/carers should inform the school immediately if there are any changes to the management plan. Please tick (✓) the appropriate box and print your answers clearly in the blank spaces where indicated. **Both sides must be signed and dated even if child does not require asthma or emergency medical plan. Information provided on this form will override all previous medical forms.**

Personal Details

STUDENT'S NAME:.....
(Surname) (First Name)

Date of birth:..... Gender: Male ☐ Female ☐

Emergency contact (e.g. parent, carer):

1. Name:..... Relationship:.....

   Phone (home):.....(work):.....(mob):.....

2. Name:..... Relationship:.....

   Phone (home):.....(work):.....(mob):.....

Doctor:..... Phone:.....

Usual Asthma Management Plan

Child's symptoms (e.g. cough):.....

Triggers (e.g. exercise, pollens):.....

Medication requirements: ASTHMATICS TO BRING THEIR ASTHMA PUFFERS TO SCHOOL EVERY DAY

NAME OF MEDICATION	METHOD (e.g. puffer & spacer, turbuhaler)	WHEN & HOW MUCH?
.....		
.....		
.....		

In an **EMERGENCY** follow the Plan below that has been ticked (✓)

Please tick (✓) the preferred box:

☐ Standard Asthma First Aid Plan

Step 1 Sit the student upright, remain calm and provide reassurance. Do not leave student alone.

Step 2 Give 4 puffs of a blue reliever puffer ***(Airomir, Asmol, Bricanyl or Ventolin)***, one puff at a time, preferably through a space device*****. Ask the student to take 4 breaths from the spacer after each puff.

Step 3 Wait 4 minutes.

Step 4 If there is little or no improvement, repeat steps 2 and 3.
If there is still little or no improvement call an ambulance immediately (Dial 000).
Continue to repeat steps 2 & 3 while waiting for the ambulance.

***** Use a blue reliever puffer ***(Airomir, Asmol, Bricanyl or Ventolin)*** on its own if no spacer is available.

OR

☐ My Child's Asthma First Aid Plan (attached)

Additional comments:

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I authorise school staff to follow the preferred **Asthma First Aid Plan** and 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. Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms at school.

Signature of Parent/Carer:..... Date:.....

I verify that I have read the preferred **Asthma First Aid Plan** and agree with its implementation.

Signature of Parent/Carer:..... Date:.....

Student Emergency Medical Plan

ASTHMA PLAN pto

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This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner). Parents/carers should inform the school immediately if there are any changes to the management plan. Please tick (✓) the appropriate box and print your answers clearly in the blank spaces where indicated. **Both sides must be signed and dated even if child does not require asthma or emergency medical plan. Information provided on this form will override all previous medical forms.**

Personal Details

STUDENT'S NAME:……
(Surname) (First Name)

Date of birth:……..…… Gender: Male ☐ Female ☐

Emergency contact (e.g. parent, carer):

1. Name:…….. Relationship:……

   Phone (home):……(work):……..……..(mob):……

2. Name:…….. Relationship:……

   Phone (home):……(work):……..……..(mob):……

Doctor:…… Phone:……..

Usual Management Plan:

MEDICAL CONDITION: ……..

Child's symptoms (e.g. rash, breathing difficulties)……..

Triggers (e.g. nuts, eggs, bee sting):……

Medication requirements:

EPIPENS (ADRENALINE AUTO INJECTORS) & OTHER EMERGENCY MEDICATIONS TO BE SUPPLIED TO THE SCHOOL

NAME OF MEDICATION	METHOD (e.g. Epipen injection, antihistamine tablet etc)	WHEN & HOW MUCH?

In an **EMERGENCY** follow the Plan below that has been ticked (✓)

Please tick (✓) the preferred box:

☐ Standard First Aid Plan

Step 1 Sit the student upright, remain calm and provide reassurance. Do not leave student alone.
Step 2 If student unconscious, follow the DRABC or EAR/CPR first aid action plan. Do not leave student alone.
Step 3 Ask for someone to call the ambulance.
Step 4 Continue with first aid treatment as necessary while waiting for the ambulance.

OR

☐ My Child's Emergency First Aid Plan

Medication instructions & treatment required:

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I authorise school staff to follow the preferred **First Aid Plan** and assist my child with taking the abovementioned medication should they require help. I will notify you in writing if there are any changes to these instructions.

Signature of Parent/Carer:……..…… Date:……

I verify that I have read the preferred **Asthma First Aid Plan** and agree with its implementation.

Signature of Parent/Carer:……..…… Date:……