OAK PARK PRIMARY SCHOOL
SCHOOL ASTHMA MANAGEMENT PLAN 2015

Student's Name _____

Grade:_____ **Age:**_____ **Date of Birth** _____/_____/_____

Parent/s / Guardian's Names:_____

Phone: Home ( ) _____Work ( ) _____Mobile_____

ASTHMA ACTION PLAN SIGNED BY YOUR DOCTOR, MUST BE SUPPLIED TO THE SCHOOL

This section is to be completed by the student's parent/guardian.

1. What are the student's usual symptoms of asthma?

Wheezing □ Tightness in chest □ Coughing □
Difficulty in breathing □

Other (please describe)_____

2. What are the student's signs / symptoms of worsening asthma?

Please describe_____

PREFERRED EMERGENCY ACTION PLAN

Victorian Schools Asthma Policy for Emergency Treatment of an Asthma Attack. (section 4.5.7.8 of the Department of Education Schools of the Future Reference Guide, 1996).

1. Sit the student down and remain calm to reassure the student.
2. Without delay give 4 separate puffs of a Reliever inhaler using 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 puffs, as per step 2.
4. If 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.

USUAL ASTHMA MANAGEMENT PLAN

Students Emergency Treatment (if different from above).

MEDICATION	DOSAGE (eg 2 puffs)	METHOD (eg puffer and spacer)	HOW OFTEN (eg every 4 mins)
Additional Comments. e.g.. Student needs medication PRIOR to exercise/sports?			

Important

⇒ Please notify any changes in writing.

⇒ A more detailed asthma management plan will be required for overnight school excursions and camps.

⇒ Other relevant information eg: trigger factors, side effects from medication etc.

_____

_____

_____

**** If you wish to discuss matters pertaining to this Management Plan, please contact the school on 9306 9182**

Declaration

In the event of an asthma attack at school, I agree to my son/daughter receiving the treatment described above. I also agree
to pay all expenses incurred for any medical treatment deemed necessary.

Parent/Guardian's Signature:_____

Date: _____/_____/15

AN INHALER &A SPACER MUST BE SUPPLIED TO THE SCHOOL

ALL MEDICATION REQUIRED BY THE STUDENT MUST BE HANDED IN TO THE OFFICE.

STUDENTS MUST NOT BE IN CHARGE OF THEIR OWN MEDICATIONS