FORM 8 - ASTHMA MANAGEMENT & EMERGENCY RESPONSE PLAN

Singleton Primary School

Name: _____ **DOB:** _____ **Year:** _____ **Form:** _____

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 Ttick appropriate box	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage instructions Tick appropriate box(es)	Stored at school Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐	Stored at school Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐	Stored at school Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐

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:	Medical Practitioner (if required): Date:

Review Date:

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.