

**STUDENT ASTHMA RECORD**

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 is any change in the management plan. Please tick (✓) the appropriate box, and print your answers clearly in the blank spaces where indicated.

<b>Personal Details</b>		
Student's name: .....	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
(Surname)	(First Name)	
Date of Birth: ...../...../.....	Form/Class:.....	Teacher:.....
Emergency Contact (e.g. parent, carer):		
(a) Name.....	Relationship .....	
Telephone No:.....	(Hm) .....	(Wk) .....
(b) Name.....	Relationship .....	
Telephone No:.....	(Hm) .....	(Wk) .....
Doctor: .....	Telephone No .....	

<b>Usual Asthma Management Plan</b>		
Child's symptoms (e.g. cough): .....		
Triggers (e.g. exercise, pollens): .....		
<b>Medication Requirements</b>		
Name of Medication	Method (e.g. puffer & spacer, turbohaler)	When, and how much?

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

**Standard Asthma First Aid Plan** Please tick (✓) the preferred box

**Step 1** Sit 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 spacer device\*. Ask 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 and 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:**.....

I authorize school staff to follow the preferred Asthma First Aid Plan & assist my child with taking asthma medications 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 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 Doctor:** ..... **Date:** ...../...../.....