FORM 8 – ASTHMA
MANAGEMENT & EMERGENCY RESPONSE PLAN

60 Kelvin Street, Maylands 6051
Phone: (08) 9462 6700
Email: maylandspeninsula.ps@education.wa.edu.au

PLEASE RETURN THIS FORM TO ADMINISTRATION OFFICE

Student Name:

Year:	**Form:**	**Teacher:**

DOB: **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**

SECTION A – ASTHMA MANAGMENT – TO BE COMPLETED BY THE PARENT/CAREGIVER
(Please list specific allergens and most recent reactions in the table below)

List of known triggers			
Dust	☐	Exercise	☐
Pollen	☐	Dander *(Animal Fur)*	☐
Smoke	☐	Common Cold	☐
Other: (*Please specify)*	☐		

SECTION B – DAILY MANAGEMENT (*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/guardian** **c) Keep giving 4 puffs of blue reliever inhale every 4 minutes, until the ambulance arrives. 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 / GUARDIAN)*

	MEDICATION 1		MEDICATION 2		MEDICATION 3	
Name of Medication						
Expiry Date						
Dose / frequency *(As per pharmacist's label)*						
Duration Dates:	**From:**		**From:**		**From:**	
	To:		**To:**		**To:**	
Route of Administration						
Administration *Tick appropriate box*	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage Instructions *Tick appropriate box(es)*	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

SECTION E – AUTHORITY TO ACT

This asthma management and emergency response plan authorises school staff school staff to provide health care support for my/our child in accordance with the above plan and/or the attached plan from a medical practitioner.

It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent Caregiver Name:	
Parent/Caregiver Signature:	**Date:**
Medical Practitioner Signature: ***(If required at the principal's discretion)***	**Date:**

☐ **If you are completing this form online and are unable to sign this form, please check this box to confirm the above information is true and correct.**

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:	

Maylands Peninsula
PRIMARY SCHOOL

FORM 12 – RECORD OF HEALTH CARE SUPPORT ADMINISTRATION OF MEDICATION

60 Kelvin Street, Maylands 6051
Phone: (08) 9462 6700
Email: maylandspeninsula.ps@education.wa.edu.au

Student:

Year: **Form:** **Teacher:**

DOB: **Gender:** ☐ Male ☐ Female ☐ Other

RECORD OF HEALTH CARE SUPPORT / ADMINISTRATION OF MEDICATION

DATE	TIME	MEDICATION	DOSAGE	STAFF MEMBERS NAMES		SIGN / INITIALS	