STUDENT ASTHMA RECORD

ELEMENT 4.4 RECORDS MANAGEMENT

ST MONICA'S SCHOOL

STUDENT NAME:		GENDER	M	F
ADDRESS:		DOB		
TEACHER:		YEAR LEVEL		
DOCTOR:		PHONE NO:		

EMERGENCY CONTACT 1	EMERGENCY CONTACT 2
Name:	Name:
Address:	Address:
Relationship:	Relationship:
Phone Number:	Phone Number:

Usual Asthma Management Plan

Symptoms	Triggers

Medication Requirements

NAME OF MEDICATION:	METHOD OF ADMINISTERING THE MEDICATION Puffer, Spacer, Nebuliser, Oral	DOSAGE/TIMES

Note the name of the Parent/Guardian requesting the Asthma Plan for a Student at St Monica's School.

Name:

Relationship: Contact Phone No.

I consent to the plan outlined being implemented as required: YES / NO
(circle one)

67 Lorrimer Street, OAKEY QLD 4401
Ph: 07 46 911 067 Fax: 07 46 911 416 Email: oakey@twb.catholic.edu.au

In an EMERGENCY follow the plan below that has been ticked ✔

☐ **STANDARD ASTHMA FIRST AID PLAN**

Step 1	Sit the student upright, remain calm and provide reassurance. Do not leave the student
Step 2	Give 4 puffs of a blue reliever puffer (Airomir, Asmol, Bricanyl or Ventolin)
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 (000)
	Continue to repeat steps 2 and 3 while waiting for the Ambulance
Use a blue reliever puffer(Airomir, Asmol, Bricanyl or Ventolin)on it's own if spacer not available	

☐ **MY CHILD'S ASTHMA FIRST AID PLAN - (attached)**

Additional Comments	

Parent/Guardian/Carer Statement

I, ____ authorise St Monica's 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/Guardian/Carer: ____________________________________

Date of Authority: ____________________________________

Doctor's Statement

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

Signature of Doctor: _______________________________ Date: ______________________