ARANMORE ASTHMA MANAGEMENT & EMERGENCY RESPONSE PLAN

NAME:	DATE OF BIRTH:	YEAR:

1. Health condition – Asthma

List known trigger(s): Dust ☐ Pollen ☐ Smoke ☐ Exercise ☐ Animal Fur ☐ Cold/Flu ☐
Other:

Daily management planning (if required):

2. Management instructions in the event of an asthma attack

Steps	Instructions
Step 1	Sit student upright, provide reassurance, and remain calm. Remain with student.
Step 2	Give 4 puffs of blue reliever inhaler. Use spacer if available. Use one puff at a time and ask 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/caregiver**
	  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 parent/caregiver has not arrived**

3. Medication instructions (Note: Medications to be provided by the parent/caregiver)

	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:		From: 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	☐ ☐ ☐ ☐ ☐

4 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:	Medical Practitioner(if required):
Date:	Date:
Review date:	Correction Factor

OFFICE USE ONLY	
Date received:	Date uploaded to SEQTA:
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, add to student file.