SCHOOL CAMP ASTHMA ACTION PLAN

THE ASTHMA FOUNDATION Victoria

FORM ONE - PRE CAMP ASSESSMENT

This record is to be completed by parents/carers in consultation with their child's doctor (general practitioner).Please inform your GP about completing the form when you make your appointment Please tick the appropriate box and print your answers clearly in the blank spaces where indicated.
This school is collecting information on your child's asthma so we can better manage asthma while your child is in our care. The information on this Plan is confidential. All staff that care for your child will have access to this information. It will only be distributed to them to provide safe asthma management for your child at school. The school will only disclose this information to others with your consent if it is to be used elsewhere. Please contact the school at any time if you need to update this Plan or you have any questions about the management of asthma at school. If no Asthma Action Plan is provided by the parent/carer, the staff will treat asthma symptoms as outlined in the Victorian Schools Asthma Policy **(Section 4.5.10.3 of the Department of Education and Early Childhood Development Victorian Government Schools' Reference Guide)**.

STUDENT'S PERSONAL DETAILS

Student's Name_____ **Gender** M F

Date of Birth ___/___/___ **Form/Class**_____ **Teacher**_____

Ambulance Membership Yes No **Membership No.**_____

What other health management plans does this student have, if any? _____

Emergency Contact (e.g. parent/carer)

Name_____**Relationship**_____

Ph: (H) _____ **(W)** _____ **(M)** _____

Doctor_____ **Ph:** _____

PHOTO

USUAL ASTHMA ACTION PLAN

Usual signs of student's asthma:

☐ Wheeze ☐ Tight Chest ☐ Cough ☐ Difficulty breathing ☐ Difficulty talking ☐ Other_____

Signs student's asthma is getting worse

☐ Wheeze ☐ Tight Chest ☐ Cough ☐ Difficulty breathing ☐ Difficulty talking ☐ Other_____

Student's Asthma Triggers

☐ Cold/flu ☐ Exercise ☐ Smoke ☐ Pollens ☐ Dust ☐ Other (please describe)_____

Asthma Medication Requirements (Including relievers, preventers, symptom controllers, combination)

Name of Medication (e.g. Ventolin, Flixotide)	**Method (e.g. puffer & spacer, turbuhaler)**	**When and how much? (e.g. 1 puff in morning and night, before exercise)**

Does the student need assistance taking their medication? Yes No If yes, how? _____

Any other information that will assist with the asthma management of the student while on camp
e.g. peak expiratory flow, night time asthma or recent attacks

_____

_____

_____

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_____

ASTHMA FIRST AID PLAN

Please tick preferred Asthma First Aid Plan

☐ **Victorian Schools Asthma Policy for Asthma First Aid**

(Section 4.5.10.3 of the Department of Education and Early Childhood Development Victorian Government Schools' Reference Guide)

Step 1. Sit the person upright
- be calm and reassuring
- Do not leave them alone.

Step 2. Give medication
- Shake the blue reliever puffer
- Use a spacer if you have one
- Give 4 separate puffs into a spacer
- Take 4 breaths from the spacer after each puff

*You can use a Bricanyl Turbuhaler if you do not have access to a puffer and spacer
Giving blue reliever medication to someone who doesn't have asthma is unlikely to harm them

Step 3. Wait 4 minutes
- If there is no improvement, repeat steps 2.

Step 4 If there is still no improvement call emergency assistance **(DIAL 000).**
- Tell the operator the person is having an asthma attack
- Keep giving 4 puffs every 4 minutes while you wait for emergency assistance

Call emergency assistance immediately (DIAL 000) if the person's asthma suddenly becomes worse

OR

☐ **Student's Asthma First Aid Plan** (if different from above)

- Please notify me if my child regularly has asthma symptoms at school.
- Please notify me if my child has received Asthma First Aid.
- In the event of an asthma attack, I agree to my son/daughter receiving the treatment described above.
- I authorise school staff to 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.
- I agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent's/Guardian's Signature: _____ Date___/___/___

Doctor's Signature: _____ Date___/___/___

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly® Schools Program or asthma management please contact **The Asthma Foundation of Victoria** on **(03) 9326 7088**, toll free **1800 645 130**, or www.asthma.org.au