ENDEAVOUR SPORTS HIGH SCHOOL
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 are any changes to the management plan. Please tick ☑ the appropriate box, and print your answers clearly in the blank spaces where indicated.

Student's name: .... Gender: M F
(Surname) (First Names)

Date of birth ...../...../..... Class ..... Teacher .....

DOES YOUR CHILD HAVE ASTHMA **Yes** ☐ **No** ☐
If yes, please complete details below **TICK APPLICABLE BOX**

Emergency Contact (eg parent or carer):

a Name..... Relationship .....
Telephone ..... (Home) Telephone ..... (Work)

b Name..... Relationship .....
Telephone ..... (Home) Telephone ..... (Work)

Doctor ..... Telephone .....

Usual Asthma Management Plan

Child's Symptoms (eg cough) .....

Triggers (eg exercise, pollens) .....

Medication Requirements:

Name of Medication	Method (eg puffer & spacer, turbuhaler)	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 the student upright, remain calm and provide reassurance. Do not leave student alone.
Step 2 Give 4 puffs of a blue reliever puffer *(Airomir, Asmol, Epaq or Ventolin)*, one puff at a time, preferably through a spacer device*. Ask the 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, Epaq or Ventolin) on its own if no spacer is available.

OR

☐ **My Child's Asthma First Aid Plan (attached)**

Additional Comments: .....

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I authorise the 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/Carer: ..... **Date:** .....

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

Signature of Doctor:..... **Date**:.....