FORM 42

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 is any change in the management plan. Please tick (✓) the appropriate box, and print your answers clearly in the blank spaces where indicated.

Personal Details

Student's name: …… Gender: M ☐ F ☐
(Surname) *(First Name)*

Date of Birth: ……/……/……. Form/Class:…… Teacher:……..

Emergency Contact *(e.g. parent, carer)*:

(a) Name……... Relationship ……..
Telephone No:…… (*Hm*) ……..……(*Wk*)

(b) Name……... Relationship ……..
Telephone No:…… (*Hm*) ……..……(*Wk*)

Doctor: ……. Telephone No ……...

Usual Asthma Management Plan

Child's symptoms (e.g. cough): ……...

Triggers (e.g. exercise, pollens):……...

Medication Requirements

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

OR

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

Additional Comments:……
……

I authorize school staff to follow the preferred Asthma First Aid Plan & assist my child with taking asthma medications 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 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**: ……/……/…….

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