Спілка Української Молоді
Осередок ім. Гет. Івана Мазепи – Мельборн
Ukrainian Youth Association – Melbourne Inc.

Asthma Management Plan

Student's Name: _____

Age: _____ Date of Birth: _____

Parent's / Guardian's Names:_____

Address:_____

Phone: Home ( ) _____ Work:_____ Mobile:_____

Emergency Contact Name:_____ Phone: _____ Mobile _____

Doctor's Name:_____ Phone: _____

Doctor's Address:_____

Medicare Number:_____

Ambulance Subscriber: YES / NO : (Subscriber No.) _____

Please answer all Questions in detail:

1. What are the child's trigger factors?_____

_____

2. Does the child suffer from any allergies? _____

_____

3, Does the student have any particular dietary requirements? If YES : please describe.

_____

_____

4. Is medication usually required daily?

YES / NO

If YES: please fill in the table:

Medication	Dosage	How Often and When?	Method

5. Does the child use a Peak Flow Meter? If YES: please write their readings below:

Lowest Reading:_____ Highest Reading:_____

6. Does the Student need pre exercise medication?

Medication:_____

Dosage: _____

YES / NO (If yes please provide the Following information)

Under What circumstances? (eg. Running)

_____

_____

7. Does the child need assistance/ supervision from staff while taking medication?

YES / NO (If yes , please provide Instructions)

Instructions:_____
_____
_____
_____

8. Any other Information that will assist the staff to manage your child's Asthma?

_____

_____

DECLARATION:
In the event of an asthma attack while at school, I agree to my son/ daughter receiving treatment described above and/ or any other medical attention deemed necessary by a Medical practitioner. I agree to pay all expenses incurred for any medical treatment deemed necessary including calling an ambulance.

Parent's/ Guardian's Signature_____ Date: _____

I understand that it is my responsibility to notify the Ukrainian Youth Association of any changes to these details

EMERGENCY ACTION PLAN

This section is to be completed by the student's Doctor in consultation with their Parent or Guardian.

1. What are the student's usual symptoms of Asthma? (✓)
   Wheezing ☐ Tightness in chest ☐ Coughing ☐ Difficulty in breathing ☐
   Other please specify:_____

2. What are the student's signs / symptoms of worsening Asthma?
   Please describe:_____

3. Has the student been admitted to hospital due to Asthma in the past 12 months? Yes No

4. Has the student ever had a sudden severe attack requiring hospitalisation? Yes No

5. Has the student been on oral corticosteroids (eg prednisolone) in the last 12 months? Yes No

6. Please tick the preferred Emergency Plan:

☐

Victorian Schools Asthma Policy for Emergency treatment of an Asthma Attack.

1. Sit student down and remain calm to reassure student.
2. Without delay give 4 PUFFS of a reliever inhaler : (Ventolin Respolin Asmol or Bricanyl) using a spacer .
3. Wait 4 minutes. If there is no improvement give another 4 puffs as per step 2.
4. If no improvement call an ambulance (Dial 000) immediately and state that " a student is having an Asthma attack."
5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

☐

Student's Emergency Treatment (If different from above)

Medication	Dosage	Method	How Often

Comments:

Doctor's Approval:
The above management plan is provided for _____ . His / her asthma is under control .
Doctor's comment (if any)

Doctor's Signature: **Date:**