Kapooka Public School

Asthma

Our school is an “Asthma Friendly School” and to keep our “Asthma Friendly title from The Asthma Foundation of NSW, the school is required to keep a “Student Asthma Record” for each child that suffers from asthma.

Asthma affects as many as one in five children. An asthma attack can come on suddenly at any time. To ensure the right management of your child in the event of an asthma attack at school, please complete the form on the back. If your child uses a spacer, you are encouraged for one to be left at school with their medication in the event of a sudden asthma attack. Please put these in a polythene bag clearly marked with the child’s name and class, medication and dosage.

Should we not be supplied with medication or a spacer, in the event of an emergency asthma attack, your child will be given the school spacer with a reliever medication (Ventolin) to ease their symptom and the parent/caregiver contacted. This is the latest recommendation from the Asthma Foundation.

Children may carry their Ventolin puffer on their self if this is preferred by you.

Please complete and sign the Student Asthma Record (see over) for our school records.

Please tick which Asthma Plan you wish the school to follow for your child in the case of an asthma attack.

Thank you.

Lyn Eacott
Principal

Privacy notice:
The information requested on the form is essential for assisting the school to plan for the support of your child’s health needs. It will be used by the NSW Department of Education and Training for the development of arrangements with you to support your child’s health needs. Provision of this information is voluntary. If you do not provide all or any of this information, the school’s capacity to support your child’s health needs could be impaired. This information will be stored securely. You may correct any personal information at any time for contacting the Principal.
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.

Personal Details

Student’s name: ………………………………………………………………………………. Gender: M ☐ F ☐

Surname: ………………………………………………………………………………. (First Name)

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

Emergency contact (eg, parent, carer):

a. Name: ………………………………………………………………………………. Relationship: …………………………………………..

Telephone No: ………………………………...(Hm) ……………………………………………………..(Wk)

b. Name: ………………………………………………………………………………. Relationship: …………………………………………..

Telephone No: ………………………………...(Hm) ……………………………………………………..(Wk)

Doctor: ………………………………………………………………………………. Telephone No: …………………………………………..

Usual Asthma Management Plan

Does the child tell the carer when he/she needs medication? ☐ Yes ☐ No

Child’s symptoms (eg, cough): ………………………………………………………………………………………………………

Triggers (eg, exercise, pollens): ………………………………………………………………………………………………………

Medication requirements:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Method (eg, puffer &amp; spacer, turbohaler)</th>
<th>When and how much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 (Airomir, Asmol, 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.

Continue to repeat steps 2 and 3 while waiting for the ambulance.

* Use a blue reliever (Airomir, Asmol or Ventolin) on its own if no spacer is available.

OR

☐ My child’s Asthma First Aid Plan (see attached).

Any additional Comments: ………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………..

I authorise 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: ………………………………..