IONA PRESENTATION PRIMARY SCHOOL

FORM 2 Asthma Medication/Record

This record is to be completed by Parents/Carers in consultation with their child's medical practitioner. Parents/Carers should inform the school immediately if there are any changes to this record. Please tick (✓) the appropriate box or print clearly your responses in the blank spaces where indicated. For some questions you may need to tick more than one box.

Student's name _____ Sex: M ☐ F ☐
(Family Name) (First Name)

Date of Birth _____ Class_____ Teacher_____

Emergency contact (e.g. Parent, Carer):

(a) Name _____ Relationship _____

Telephone No's: Home: _____ Work: _____ Mobile: _____

(b) Name _____ Relationship _____

Telephone No's: Home: _____ Work: _____ Mobile: _____

General Practitioner: _____ Telephone No: _____

Specialist (if applicable):_____ Telephone No: _____

1. How often does your child have asthma symptoms?
   - ☐ Infrequently (less than 5 times per year)
   - ☐ Frequently (more than 5 times per year)
   - ☐ Most days/daily
   - ☐ Usually when exercising

2. How will the school staff recognize that your child is having an asthma attack?
   - ☐ Wheeze (whistling noise from chest)
   - ☐ Cough
   - ☐ Tightness in chest
   - ☐ Difficulty with breathing
   - ☐ other _____

   How will they recognize if your child's asthma is worsening?

   _____

   _____

3. What are your child's allergies / triggers for asthma?

   _____

4. Does your child take any asthma medication *before exercise* Yes ☐ No ☐

Medication	Method used e.g. puffer with spacer, turbuhaler	How much and how often?

5. Does your child require asthma medication *everyday at school* Yes ☐ No ☐

Medication	Method used e.g. puffer with spacer, turbuhaler	How much and how often?

What *reliever* medication does your child take for asthma symptoms at school?

Medication	Method used e.g. puffer with spacer, turbuhaler	How much?

6. Does your child *initiate* the use of their asthma medication? Yes ☐ No ☐
7. Does your child need *assistance* to take asthma medication? Yes ☐ No ☐

8. If my child has an asthma attack at school, please follow to the best of your ability the steps outlined below in the EMERGENCY ACTION PLAN.

Step 1	Sit the student comfortably in an upright position Be calm and reassuring
Step 2	Without delay give 4 puffs of RELIEVER medication (blue/grey inhaler) E.g. Ventolin, Respolin, Asmol, Respax, Bricanyl Give with a spacer if available – 2 puffs every 4 breaths
Step 3	Wait 4 minutes If little or no improvement repeat Step 2
Step 4	Call an Ambulance (000) immediately if: - there is still little or no improvement - there is severe difficulty breathing or speaking - there is blueness around the mouth - if at any time you are concerned Continuously repeat Steps 2 to 3 whilst waiting for the Ambulance

Note: If your child requires a different Emergency Action Plan please attach a copy.

I agree with this Emergency Action Plan and authorize 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. 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 this school-based Emergency Action Plan and agree with its implementation

Signature of Doctor: _____ Date: _____