VILLANOVA COLLEGE

STUDENT ASTHMA RECORD

This record is to be completed by parents/guardians in consultation with their child's doctor (general practitioner). Parents/guardians should inform Villanova College 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:		Date of Birth:	
Year Level/Class:		Teacher:	
Emergency Contact			
Name:		Relationship to Child:	
Mobile Phone No.:		Alternate Phone:	
Name:		Relationship to Child	
Mobile Phone No.:		Alternate Phone:	

Usual Asthma Management Plan

Child's symptoms (e.g. cough): .....

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

Medication Requirements			
Name of Medication	**Method (e.g. puffer and spacer or turbohaler)**	**Time to be administered**	**Dosage required**

In an emergency please follow the Plan below that has been ticked (please tick preferred box)

☐ **Standard Asthma First Aid Plan**

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 (use puffer on its own if no spacer is available)
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

OR

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

Additional Comments: .....

I authorise school staff to follow the preferred Asthma First Aid Plan and 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/Guardian: ..... Date: ...../...../.....

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

Signature of Doctor: ..... Date: ...../...../.....