ASTHMA MANAGEMENT PLAN

(To be completed by the Child's Doctor and Parents)

CHILD'S PHOTO

Child's name: _____ **Age:**_____ **D.O.B.**_____

Contact in case of emergency: Name:_____**Phone Number:**_____

RISK MINIMISATION PLAN

POSSIBLE SIGNS & SYMPTOMS:

Please Indicate:

- Wheezing
- Tightness in chest
- Coughing
- Difficulty breathing/speaking
- Other (please specify)

TRIGGERS:

- Exercise
- Colds/viruses
- Pollens/dust
- Other (please specify)

SEVERITY OF ASTHMA:

- ☐ Well Controlled
- ☐ Getting Worse
- ☐ Severe

My Child's Emergency Action Plan *From parent/carers with legal responsibility for the student whilst attending SACCS*

Medication	Dosage (e.g. 2 puffs)	Method (e.g. puffer and spacer)	How often (e.g. every four minutes)

Please have the child's doctor fill out the part below and sign

Reliever Medication:_____ Dose:_____

Frequency:_____ Device (e.g. spacer):_____

Childs Reaction to the Medication:_____

Doctor's Name:_____Address:_____Doctor's Signature:_____Ph:_____

****ALL MEDICATIONS WILL BE ADMINISTERED UNDER ADULT SUPERVISION**

THIS CHILD'S MEDICATION IS FOUND IN THE ASTHMA BASKET IN THE SACCS OFFICE **

AUTHORISATION FOR MANAGEMENT PLAN TO BE FOLLOWED:

I/we…….. being the parent/guardian of…… hereby authorise an educator/staff member to administer asthma medication to my child, if necessary. Medication provided by me, the parent, will be in accordance with OSHC service policy and procedures and shall be kept at the OSHC service. I will notify you in writing if there are any changes to these instructions.

Parent signature: _____Date: _____Coordinator signature: _____Date: _____