



Asthma Action Plan for Schools

Students name: _____ Date of birth: _____

Address: _____

Parent/caregiver: _____ Phone: _____ Mob: _____

Alternative contact: _____ Phone: _____ Mob: _____

Usual Doctor: _____ Phone: _____

Please describe your child's asthma: _____

What brings on your child's asthma?

- cats
- dogs
- pollen
- mould
- fumes
- cold air
- dust & dust mites
- chalk dust
- foods
- humidity
- chest infections
- smoke

Has your Doctor written an Asthma Action Plan? Yes No

For an Asthma Action Plan contact your Doctor or Asthma Nurse Educator — phone 04 237 4520

Medicines to take each day at school:

How much? _____ How often? _____

Medicines to take before exercise:

Name of medicine: _____

How much? _____ How often? _____

Medicines to take for an asthma attack: (wheeze, shortness of breath, persistent cough)

Name of medicine: _____

How much? _____ How often? _____

Note: _____'s inhaler(s) is/are kept _____

PLEASE CONTACT THE SCHOOL IF THERE ARE ANY CHANGES TO MEDICINES

I agree to the school administering a reliever inhaler to my child in an emergency.

I understand that the school will inform me if this medicine is used.

Signed: _____ Date: _____

It

is

the parent's responsibility to talk with the family doctor about their child with asthma

School staff note: call an ambulance if the student — can't walk, talk or breathe because of asthma, or

- if there is blueness of the lips, or
- if there is no response to the reliever inhaler, or
- if they look very ill