



ROWVILLE AND DISTRICT NEIGHBOURHOOD HOUSE INC.

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ASTHMA INFORMATION SHEET

Child Name: _____ Age: _____

Parent/Guardian Information

Name: _____ Name: _____

Contact Numbers: 1. _____ Contact Numbers: 1. _____
 2. _____ 2. _____

USUAL ASTHMA MANAGEMENT PLAN

Usual signs of child's asthma	Worsening signs of child's asthma	What triggers the child's asthma?
Wheezing <input type="checkbox"/>	Wheezing <input type="checkbox"/>	Exercise <input type="checkbox"/>
Tightness in Chest <input type="checkbox"/>	Tightness in Chest <input type="checkbox"/>	Colds/Viruses <input type="checkbox"/>
Coughing <input type="checkbox"/>	Coughing <input type="checkbox"/>	Pollens <input type="checkbox"/>
Difficulty in breathing <input type="checkbox"/>	Difficulty in breathing <input type="checkbox"/>	Dust <input type="checkbox"/>
Difficulty in speaking <input type="checkbox"/>	Difficulty in speaking <input type="checkbox"/>	Other Triggers <input type="checkbox"/>
Other (Please describe) <input type="checkbox"/>	Other (Please describe) <input type="checkbox"/>	(Please indicate)

Medication requirements usually taken at school:

(including preventers, symptom controllers, medication before exercise)

Name of Medication	Method (e.g. puffer & spacer, turbuhale)	When, and how much

Does your child need assistance taking their medication? Yes No

Asthma First Aid Plan

Please tick () preferred First Aid Plan: Please note - a doctor's signature is only required if an individual plan is being written for your child. You may already have an individualised plan prepared by your family doctor for your child. Please photocopy and return with this form.

<p>Rowville and District Neighbourhood House Vacation Care Asthma Policy for Emergency Treatment of an Asthma Attack</p> <ol style="list-style-type: none">1. Sit the child down and remain calm to reassure the student.2. Without delay shake a blue reliever puffer (Ventolin) and give 4 separate puffs, through a spacer (spacer technique – 1 puff/take 4 breaths from spacer, repeat until 4 puffs have been given).3. Wait 4 minutes. If there is no improvement, give another 4 separate puffs, as per step 2.4. Wait 4 minutes. If there is no improvement, call an ambulance (dial 000) immediately and state that <i>“a child is having an asthma attack”</i>.5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.
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This section can be used for your child's asthma emergency plan, and if it does vary from your child's asthma plan, it must be completed and signed by a doctor.

Child's Emergency Treatment (if different from above)

In the event of an asthma attack at the Rowville and District Neighbourhood Vacation Care Program, I agree to my son/daughter receiving the treatment described above. I authorise a staff member with Level 2 First Aid Certificates 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 notify me if my child regularly has asthma symptoms during the program. I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent's/Guardian's Signature: _____ Date: ___/___/_____