St Columba College
A joint Anglican and Catholic College

Asthma Management Plan

THIS ASTHMA PLAN IS TO BE COMPLETED AND SIGNED BY A **MEDICAL PRACTITIONER** AND IS UPDATED YEARLY.

CHILD DETAILS

FAMILY NAME:_____ DATE OF BIRTH: _____ / _____ / _____

GIVEN NAME:_____ GENDER: Male ☐ Female ☐

PREFERRED NAME:_____ CLASS / HOUSE TUTOR GROUP: _____

DEAR DOCTOR, Please indicate appropriate answers clearly:

THE STUDENT'S ASTHMA IS: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ SEASONAL

USUAL SIGNS OF STUDENT'S ASTHMA: ☐ WHEEZING ☐ TIGHTNESS OF CHEST

☐ COUGHING ☐ DIFFICULTY IN BREATHING ☐ DIFFICULTY IN SPEAKING

WHAT TRIGGERS STUDENT'S ASTHMA: ☐ EXERCISE ☐ COLDS / VIRUSES ☐ ANIMALS

☐ POLLENS ☐ DUST

☐ OTHER _____

NAME OF MEDICATION	METHOD	AMOUNT	WHEN TO BE TAKEN

DOES THE STUDENT NEED ASSISTANCE TAKING THEIR MEDICATION? ☐ YES ☐ NO

DOES THE STUDENT NEED MEDICATION BEFORE EXERCISE? ☐ YES ☐ NO

WILL THE STUDENT BE CARRYING THEIR OWN MEDICATION? ☐ YES ☐ NO

THE STUDENT'S MEDICATION WILL BE STORED IN THE FIRST AID ROOM ☐ YES ☐ NO

DOCTOR'S NAME: _____

DOCTOR'S SIGNATURE: _____ DATE: _____ / _____ / _____

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THE MEDICATION POLICY AT ST COLUMBA COLLEGE OUTLINES:

- YOUR CHILD CANNOT BE GIVEN MEDICATION UNLESS THE COLLEGE HAS RECEIVED A **MEDICATION PLAN** FROM A DOCTOR PERMITTING.
- THE STUDENT TO RECEIVE THE PRESCRIBED MEDICATION.
- FOR STUDENTS DIAGNOSED WITH ASTHMA, ALLERGIES OR ANY OTHER MEDICAL CONDITION REQUIRING MEDICATION FOR TREATMENT, THE COLLEGE MUST REQUIRE **A YEARLY UPDATED ASTHMA PLAN OR MEDICATION PLAN** SIGNED BY A DOCTOR.
- IF A STUDENT DOES NOT HAVE A SIGNED DOCTOR'S PLAN ALLOWING VENTOLIN TO BE ADMINISTERED TO THE STUDENT WHEN NEEDED, THEN A PARENT / CAREGIVER WILL BE PHONED TO COME TO THE SCHOOL, AND IF UNAVAILABLE, THEN AN AMBULANCE WILL BE CALLED AND THE PARENT / CAREGIVER WILL BE RESPONSIBLE FOR THE COSTS.
- PLEASE ALSO BE AWARE THAT AN "EMERGENCY" IS CLASSIFIED AS AN EVENT THAT REQUIRES AN AMBULANCE TO BE CALLED. THE COLLEGE AMBULANCE POLICY IS ONLY COVERED FOR INJURIES THAT RESULT IN ACCIDENTS THAT OCCUR AT THE COLLEGE.

AUTHORISATION

- IN THE EVENT THAT MY CHILD REQUIRES ASTHMA MEDICATION AS PRESCRIBED BY THE MEDICAL PRACTITIONER, I AUTHORISE ST COLUMBA COLLEGE STAFF TO ASSIST MY CHILD WITH TAKING THE MEDICATION AS PRESCRIBED BY THE MEDICAL DOCTOR.
- IF THERE ARE ANY CHANGES TO THIS PLAN, I WILL NOTIFY THE COLLEGE AND PRESENT AN UPDATED PLAN IF NECESSARY.
- I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION.

PARENT / GUARDIAN SIGNATURE

PARENT / GUARDIAN NAME: _____

PARENT / GUARDIAN SIGNATURE: _____ DATE: _____ / _____ / _____