



ST JOSEPH'S PRIMARY SCHOOL LAURIETON DIOCESE OF LISMORE

Asthma Management Policy

Policy Number:	AMP.1.2
Status:	Ratified
Date Issued:	March 2014
Evaluation and Review:	March 2017
Policy Contact Officer:	School Principal – David Hughes
Related Documentation:	

Rationale

The Principal and staff accept their responsibility to initiate treatment for children with Asthma in emergency situations.

Enrolment

- All Asthmatics to be identified on enrolment form;
- A separate register of Asthmatics will be kept in the school office.

Emergency Action Plan

- Treatment will be started as soon as symptoms commence.
- The School has a current action plan for Asthmatics which is completed with the assistance of parents/guardians and the students General Practitioner.
- The Emergency Action Plan will be kept in the school office.
- Contact to the student's parent/guardian will be made in all situations where the emergency plan was instigated.

Training

All staff members will have training provided the Asthma Foundation of N.S.W

- A log of Asthma trained First Aiders, including name, qualification, expiry, usual location, phone extension, will be kept at _____;
- This log will be maintained by the principal and / or delegate.

First Aid Kit

- An Asthma First Aid Kit will be kept including:
 - Reliever Medication
 - Spacer
 - Mouthpiece or mask
 - Emergency Action Plan
 - Medication Register
 - Forms to notify parents of attack
- The Asthma First Aid Kit will be checked by office staff.
A log of these checks will be kept..

Cleaning of Devices

- Devices (ie. Spacer) will be cleaned after every use between students by Staff member supervising.
- Spaces and mouthpieces/masks will be cleaned by soaking in a basin of warm water and a diluted disinfectant for 30 minutes; then
- Rinse in warm water, lightly shake away excess water and then air dry;
- OR as per manufacturers instructions;

Storage of Medication

- Reliever medications to be kept in Asthma First Aid Kit.
- Student to carry their own medication where agreed by both the Principal and the Parent/Guardian and relevant documentation signed.

Administration

- Administration of all medications and treatment to be made strictly as per the Emergency care plan.
- Administration can be done by all qualified staff.
- Always check you have the correct drug and check expiry date.
- Supervise the student and assist as needed.
- Record all medication administered.

Information to include on students enrolment form
(to comply with policy and procedure recommendations)

MEDICAL INFORMATION

Parent's Authority and Consent:

1. My child has the following allergies (please be very thorough)

2. My child has the following medical conditions: _____

You may be required to have an appointment with the principal to discuss these along with any specific treatment guidelines concerning the school.

3. Parents must advise school in writing concerning any medication that needs to be taken by the children at school including the appropriate forms, which can be obtained front office staff.
4. I understand that First Aid will be administered to my child by a qualified First Aider when necessary.
5. I give permission for ' _____ ' brand band-aids to be used on my child to cover an open cut or sore.
6. I give permission for staff to seek medical attention for my child if the emergency contact person or I cannot be reached.

Further specific information can be obtained by asking the administration staff for copies of the school protocol. Please advise us if you disagree with any of the above.

Signed: _____ (Parent/Guardian) Date: _____

Please Note:

You are asked to advise the school regarding any alteration to the information supplied on this form.

Agreement for students to carry their own Asthma Medications

_____ Aged _____ years,
CHILD'S NAME

of _____
SCHOOL'S NAME

is responsible to carry his/her own Asthma medication whilst on school grounds or excursions
The student is instructed to seek a teachers assistance whenever requiring to use their
medication.

Principal

Print Name & Date

Parent/Guardian Print Name & Date

<on school letterhead>

Dear Parent,

Today, _____
DATE

Your child _____
CHILD'S NAME

Required the use of _____
MEDICATION NAME

_____ puffs

_____ times

to relieve symptoms of _____
EG. COUGHING, WHEEZING, DIFFICULTY BREATHING,
TIGHTNESS IN THE CHEST

Teacher's Name
<on school letterhead>

Request for Administration of Medication

To be completed by Parent/Guardian

Name of Student: _____
Name of Prescribing Doctor: _____
Address of Prescribing Doctor: _____
Phone number of Prescribing Doctor: _____

Reason for Medication:

Medication Details

Medication Name	Dose	Time/s of Administration	Special Instructions	Self-Admin (Yes/No)

I, _____, as the Parent/Guardian of the above named student request administration of medication supplied (including necessary equipment such as medication cup) as per the above directions. I also give permission for a School representative to contact the Prescribing Doctor if confirmation or information about this is required.

Signed : _____
Parent/Guardian

Date: _____

