



4. Does your son/daughter require adrenaline (Adrenaline injection, Epi Pen or Mini Jet) when suffering from an allergic reaction? Yes/No.

**THE ALPINE SCHOOL ALLERGY MANAGEMENT PLAN.**

*This form is to be completed by your doctor.*

*Student's Name*.....

**What is the patient allergic to?**  
.....  
.....  
.....  
.....

**What are the usual signs and symptoms of the patient's reaction?**  
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.....  
.....  
.....

**What are the signs and symptoms of a worsening reaction?**  
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.....  
.....

**When experiencing an allergic reaction does your patient require? (Please circle and indicate as to whether they have ever had this emergency medication).**

<b>Medication:</b>	<b>Ever Required:</b>
Min-I-Jet	Yes/No
Adrenaline injection	Yes/No
Epi-pen Adult	Yes/No
Epi-pen Junior	Yes/No

**When was the last known contact with the allergen?      Date ..../..../.....**

**Please detail the emergency treatment for your patient when suffering from an allergic reaction and fill in the drug chart. The plan and medication outlined below will be followed by the staff at The alpine School in an emergency situation.**

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.....  
.....  
.....

Medication.	Dosage.	Method.	How Often.

*Student's Name:*.....

**In the event of an anaphylactic reaction, I consent to my son/daughter receiving the treatment described above. I also agree to pay all expenses incurred for any medical treatment deemed necessary.**

**Parent/Guardian's Signature (Please Circle):**.....

**Date:**...../...../.....

**Doctor's Comments (if any)** .....  
 .....  
 .....

**Doctor's Name:**.....

**Doctor's Signature:**.....

**THE ALPINE SCHOOL ASTHMA MANAGEMENT PLAN.**

*Student's Name*.....

**EMERGENCY ASTHMA ACTION PLAN.**

*This section is to be completed by the student's doctor in consultation with their Parent/Guardian.*

**1. What are the patient's usual symptoms of asthma? (Please tick as appropriate).**

Wheezing.    Tightness in chest.    Coughing.    Difficulty with breathing.

**Other. (Please describe)**.....  
.....

**2. Please describe the patient's signs/symptoms of worsening asthma?**.....  
.....  
.....

**Please indicate the preferred Emergency Action Plan.**

**Victorian Schools Asthma Policy for Emergency Treatment of an Asthma Attack**

**Section 4.5.7.8 of the Department of Education Schools of the Future Reference Guide.**

- 1. Sit the student down and remain calm to reassure the student.**
- 2. Without delay give 4 puffs of a Reliever Inhaler (Ventolin, Respolin or Bricanyl), using a spacer. Spacer technique = 1 puff, then take 4 breaths from spacer, repeat until 4 puffs have been given.**
- 3. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per step two.**
- 4. If there is no improvement, call an ambulance (000) immediately and state that "a student is having an asthma attack".**
- 5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.**

Student's Emergency Treatment (if different from above).

Medication.	Dosage. (e.g. 2 puffs)	Method. (e.g. puffer and spacer)	How often. (e.g. every 4 minutes)

*Student's Name*.....

<b>USUAL ASTHMA MANAGEMENT PLAN.</b>
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Please list the usual triggers of asthma?.....  
 .....

Does the student usually require medication at school? Yes/No.

If answering 'Yes' please provide the following information.

What is the usual medicine regime followed?

Medication.	Dosage.	Method.	Frequency.

Does the student need pre-exercise medication? Yes/No.

If answering 'Yes' please provide details of circumstances, medication and dosage.....  
 .....

Does the student require assistance/supervision from staff while taking her medication? Yes/No.

If answering 'Yes' please provide detailed instructions.....  
 .....  
 .....

Please use the space provided below for additional information (e.g. trigger factors side effects from medication etc.) that you may wish the Staff to be aware of.....  
 .....

Additional Comments.....  
 .....  
 .....

<b>DECLARATION:</b>
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**In the event of an asthma attack at The Alpine School, I agree to my son/daughter receiving the treatment described above. I also agree to pay all expenses incurred for any medical treatment deemed necessary.**

**Parent/Guardian Signature..... Date...../...../.....**

**Doctor's Name.....Date...../...../.....**

**Doctor's Signature.....**