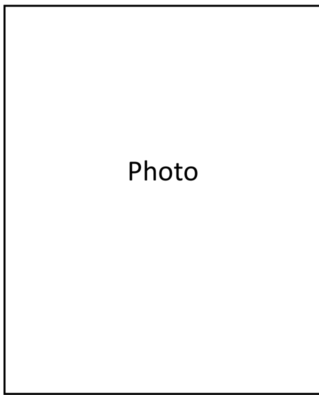

ACTION PLAN FOR STUDENTS WITH ASTHMA

PROVIDED BY PARENTS

Child's Name: ______________________________ DOB: ___________

Location of child's medication (if applicable): ______________________________

Doctor's name: ____________________________ Phone: _______________

Family emergency contact name: ___________________________________

Mobile: ________________ Work: ______________ Home:______________

PLAN

When asthma is **controlled**:

Signs:	Treatment:

When asthma is **getting worse**:

Signs:	Treatment:

When asthma is **severe:**

Signs:	Treatment:

Does your child know how to self-administer required medication and have permission to do so under supervision of an OSHC staff member? ☐ Yes ☐ No Signature: ___________________

In an emergency requiring medical attention I authorise OSHC to contact the doctor listed above and/or call an ambulance.

Name: ________________________________ Signature: _______________________ Date: _____________

I have discussed the above information with my doctor and authorise OSHC to follow what I have stated in the above action plan.

Name: _________________________________ Signature: _______________________ Date: _____________