

## MEDICAL MANAGEMENT POLICIES AND PROCEDURES

At Stella Maris Catholic Primary School, the health and safety of our students is our priority. As mandated by Melbourne Archdiocese Catholic Schools, we must have in place plans and procedures to manage our students' health care needs, including situations where we are administering medication during school hours.

### SHORT TERM MEDICATION

If your child develops a short term illness / condition during the school year (such as tonsillitis, an ear infection, common cold, school sores) and the school is asked to administer medication a **Medication Authority Form** must be completed. *It is important to have a template copy of the Medication Authority Form when taking your child to the doctor (refer website or school app).* Administering of short term medication can only be for one to two days.

### ONGOING HEALTH CARE NEEDS / MEDICAL CONDITIONS

For families with children with a diagnosed health care need, complex care need or medical condition and where **medication is required to be administered at school**, please:

1. Attend your child's AHPRA registered health practitioner to complete the **Medical Management Plan** (this must be signed by the practitioner); and
2. Complete the **Medication Authority Form** if medication is to be administered at school

If your child has...	Then...
<ul style="list-style-type: none"> <li>• Anaphylaxis</li> <li>• Epilepsy</li> <li>• Asthma</li> <li>• Allergies (including hayfever)</li> <li>• Diabetes</li> </ul>	A specific condition form/Action Plan from the health practitioner must be provided.
<ul style="list-style-type: none"> <li>• Coeliac management plan</li> <li>• Continence management plan</li> <li>• Royal Children' s Hospital Plan</li> </ul>	Please provide the plan to the school.
<ul style="list-style-type: none"> <li>• Acquired Brain Injury (ABI)</li> <li>• Cancer</li> <li>• Cystic Fibrosis</li> <li>• Supervised oral eating/drinking needs</li> <li>• Mobility/transfer/positioning needs</li> </ul>	<p>Please contact us prior to seeing your medical practitioner as we will provide you with a condition specific Medical Management Plan.</p> <p>The Medication Authority Form must be completed if medication is required to be administered at school.</p>

Once the Medication Authority Form is received at school, a staff member will contact you to arrange a consultation where a Student Health Support Plan will be developed.

#### If these documents are not provided to the school:

- Medication cannot be administered to your child.
- Your child cannot attend school or excursions.

Accordingly, **please return** the completed Medical Management Plan, Medication Authority Form and condition specific form **by Friday 30 January 2026**.

To familiarise yourself with the policy, read the following documents:

- Medical Management Plan
- Medication Authority Form (attached)
- Administration of Medication to Students - Procedures
- Medical Management Policy
- Medical Management Communication Plan

These policies are on the school website (under School Information > School Policies) and the Stella Maris app. We understand that these policies and procedures are quite comprehensive, however, we appreciate your patience and cooperation.

Yours Sincerely  
Stephen Harrison, Principal

TRANSLATION: If you require this letter to be translated contact the front office on [info@stellamaris.catholic.edu.au](mailto:info@stellamaris.catholic.edu.au)

**Filipino:** *Kung kailangan mong isalin ang liham na ito, makipag-ugnayan sa front office.*

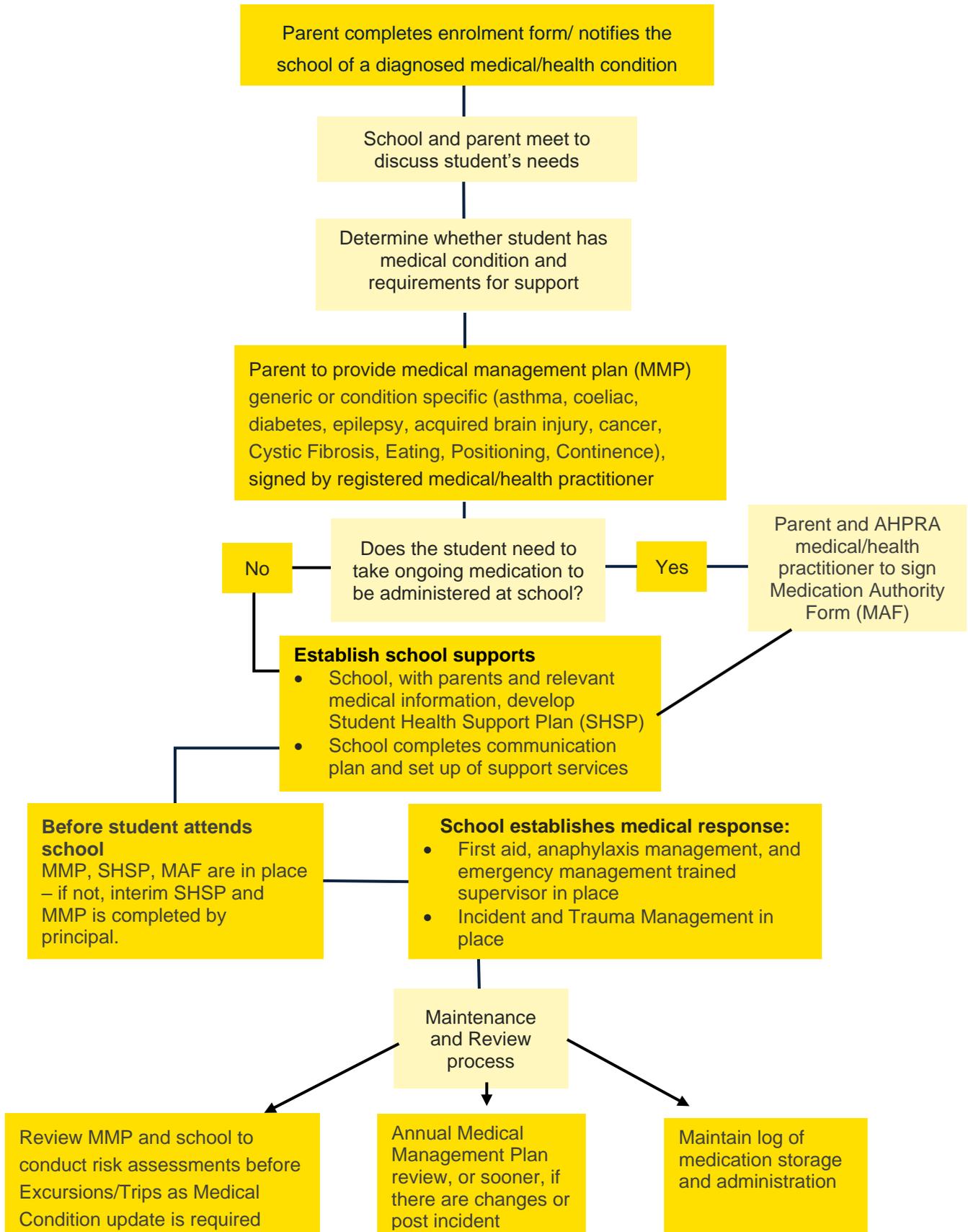
**Indonesian:** *Jika Anda memerlukan surat ini untuk diterjemahkan, hubungi kantor depan.*

**Burmese:** *ihcarko bharsarpyanraan loaautpark roneshaeshoet saatswal par .*

**Spanish:** *Si necesita que se traduzca esta carta, comuníquese con la recepción.*



# Medical Management Flowchart



<b>POLICY DATABASE INFORMATION</b>	
<b>Approval authority</b>	Director, Learning and Regional Services
<b>Approval date</b>	24 August 2023
<b>Next review</b>	Feb 2026
<b>Superseded documents</b>	MACS Medical Management Flowchart – Schools – v1.0 - 2022

## Stella Maris Catholic Primary School Medication Authority Form

This form is to be completed where parents/guardians/carers request that a student be administered medication at school or during a school activity. The principal or nominated staff member must approve all ongoing and regular administration of medication (over the counter or prescription) by the school. In most cases, medication must not be administered to a child being educated and cared for unless this form is signed by an authorised AHPRA registered medical/health practitioner.

The principal or nominated staff member may agree to proceed with the authority of parent/guardian/carer signature without the authority of an authorised AHPRA registered health/medical practitioner. This would only occur in rare cases, for example, short term (1–2 days) administration of over-the-counter medication at school or on off-site activities such as camps. No medication will be administered beyond the instruction on the original packaging unless recommended by an authorised AHPRA registered health/medical practitioner.

Schools require written permission for students to self-administer their medication from parents/guardians/carers, in consultation with registered medical or health practitioners to determine appropriate age and situation under which the student can self-administer their medication.

- Parents/guardians/carers must ensure that medication brought to the school is in its original package with original labels.
- Please note, school staff will seek emergency medical assistance if there are concerns about a student’s condition following the administration of medication.
- As a preventative measure against allergic reaction, the first dose / application of any medication required to be administered at school should be administered under the supervision of a parent / guardian / carer or health professional rather than at school.

### Student details

Name of student		Date of birth		Home Group	
Date of Medical Management Plan (if relevant)		MedicAlert Number (if applicable)		Date for Medication Authority Form	

### Requirement for medication to be administered at school

Please outline the reasons for the administration of medication at school. For ongoing medical conditions, this should generally be supported by a Medical Management Plan or a letter from the student’s treating health practitioner (e.g. diagnosis of ADHD requiring administration of Ritalin at school) (see the school’s Medical Management Policy for further information).

For short term use or once off (1–2 days), please also describe the reasons for administration of medication at school.

**Medication to be administered at school**

<b>Name of Medication</b>	<b>Dates to be administered</b> <input type="checkbox"/> Ongoing <input type="checkbox"/> Short term Start: .....  End .....	<b>Time/s to be taken</b>	<b>Dosage</b>	<b>Method (e.g. topical, oral, injected)</b>	<b>Supervision required?</b> <input type="checkbox"/> No – self managed by student <input type="checkbox"/> Yes <input type="checkbox"/> Remind <input type="checkbox"/> Observe <input type="checkbox"/> Assist <input type="checkbox"/> Administer
<b>Name of Medication</b>	<b>Dates to be administered</b> <input type="checkbox"/> Ongoing <input type="checkbox"/> Short term Start: .....  End .....	<b>Time/s to be taken</b>	<b>Dosage</b>	<b>Method (e.g. topical, oral, injected)</b>	<b>Supervision required?</b> <input type="checkbox"/> No – self managed by student <input type="checkbox"/> Yes <input type="checkbox"/> Remind <input type="checkbox"/> Observe <input type="checkbox"/> Assist <input type="checkbox"/> Administer
<b>Name of Medication</b>	<b>Dates to be administered</b> <input type="checkbox"/> Ongoing <input type="checkbox"/> Short term Start: .....  End .....	<b>Time/s to be taken</b>	<b>Dosage</b>	<b>Method (e.g. topical, oral, injected)</b>	<b>Supervision required?</b> <input type="checkbox"/> No – self managed by student <input type="checkbox"/> Yes <input type="checkbox"/> Remind <input type="checkbox"/> Observe <input type="checkbox"/> Assist <input type="checkbox"/> Administer

### Medication taken to / stored at the school – Storage requirements

Indicate if there are any specific storage instructions for any of the required medications:

### Supervision required

Students in the early years will generally need supervision of their medication and other aspects of health care management. In line with their age and stage of development and capabilities, older students can take responsibility for their own health care. Self-management should be agreed to by the student and their parents/guardians/carers, the school and the student's medical/health practitioner.

Please describe whether supervision or assistance is required by the student when taking medication at school (e.g. remind, observe, assist or administer):

Please indicate if permission is provided for the student to carry their medication (that does not have special storage requirements):

**Authorisation to administer medication in accordance with this form**

Parent/Guardian/Carer 1 Name		Parent/Guardian/Carer 2 Name	
Signature		Signature	
Date		Date	

**Please have an authorised AHPRA registered health/medical practitioner complete the following section for ongoing use of prescription and/or over the counter medication**

Practitioner name			
Name of health practice			
Address			
Telephone		Email	
AHPRA registration number		Patient URL number	
Signature		Date	

**Privacy statement**

We collect personal and health information to plan for and support the health care needs of our students. Information collected will be used and disclosed in accordance with Stella Maris published Privacy Policy.

Approval authority	Director, Learning and Regional Services
Approval date	17 April 2024
Next review	April 2025

# Minimum period of exclusion from primary schools and children's services<sup>1</sup> for infectious diseases cases and contacts

Public Health and Wellbeing Regulations 2019

## Schedule 7

Column 1 Number	Column 2 Conditions	Column 3 Exclusion of cases	Column 4 Exclusion of Contacts
1	Chickenpox	Exclude until all blisters have dried. This is usually at least 5 days after the rash appears in unimmunised children, but may be less in previously immunised children	Any child with an immune deficiency (for example, leukaemia) or receiving chemotherapy should be excluded for their own protection. Otherwise not excluded
2	Conjunctivitis	Exclude until discharge from eyes has ceased	Not excluded
3	Cytomegalovirus (CMV) infection	Exclusion is not necessary	Not excluded
4	Diarrhoeal illness*	Exclude until there has not been vomiting or a loose bowel motion for 24 hours	Not excluded
5	Diphtheria	Exclude until medical certificate of recovery is received following at least two negative throat swabs, the first not less than 24 hours after finishing a course of antibiotics and the other 48 hours later	Exclude family/household contacts until cleared to return by the Chief Health Officer
6	Glandular fever (Epstein-Barr Virus infection)	Exclusion is not necessary	Not excluded
7	Hand, Foot and Mouth disease	Exclude until all blisters have dried	Not excluded
8	Haemophilus influenzae type b (Hib)	Exclude until 48 hours after initiation of effective therapy	Not excluded
9	Hepatitis A	Exclude until a medical certificate of recovery is received, but not before 7 days after the onset of jaundice or illness	Not excluded
10	Hepatitis B	Exclusion is not necessary	Not excluded
11	Hepatitis C	Exclusion is not necessary	Not excluded
12	Herpes (cold sores)	Young children unable to comply with good hygiene practices should be excluded while the lesion is weeping. Lesions to be covered by dressing, where possible	Not excluded
13	Human immuno-deficiency virus infection (HIV)	Exclusion is not necessary	Not excluded
14	Impetigo	Exclude until appropriate treatment has commenced. Sores on exposed surfaces must be covered with a watertight dressing	Not excluded
15	Influenza and influenza like illnesses	Exclude until well	Not excluded unless considered necessary by the Chief Health Officer
16	Leprosy	Exclude until approval to return has been given by the Chief Health Officer	Not excluded
17	Measles	Exclude for at least 4 days after onset of rash	Immunised contacts not excluded. Unimmunised contacts should be excluded until 14 days after the first day of appearance of rash in the last case. If unimmunised contacts are vaccinated within 72 hours of exposure with any infectious case, or received Normal Human Immunoglobulin (NHIG) within 144 hours of exposure of any infectious case, they may return to the facility
18	Meningitis (bacterial —other than meningococcal meningitis)	Exclude until well	Not excluded
19	Meningococcal infection	Exclude until adequate carrier eradication therapy has been completed	Not excluded if receiving carrier eradication therapy
20	Mumps	Exclude for 5 days or until swelling goes down (whichever is sooner)	Not excluded
21	Molluscum contagiosum	Exclusion is not necessary	Not excluded
22	Pertussis (Whooping cough)	Exclude the child for 21 days after the onset of cough or until they have completed 5 days of a course of antibiotic treatment	Contacts aged less than 7 years in the same room as the case who have not received three effective doses of pertussis vaccine should be excluded for 14 days after the last exposure to the infectious case, or until they have taken 5 days of a course of effective antibiotic treatment
23	Poliovirus infection	Exclude for at least 14 days from onset. Re-admit after receiving medical certificate of recovery	Not excluded
24	Ringworm, scabies, pediculosis (head lice)	Exclude until the day after appropriate treatment has commenced	Not excluded
25	Rubella (German measles)	Exclude until fully recovered or for at least four days after the onset of rash	Not excluded
26	Severe Acute Respiratory Syndrome (SARS)	Exclude until medical certificate of recovery is produced	Not excluded unless considered necessary by the Chief Health Officer
27	Shiga toxin or Verotoxin producing Escherichia coli (STEC or VTEC)	Exclude if required by the Chief Health Officer and only for the period specified by the Chief Health Officer	Not excluded
28	Streptococcal infection (including scarlet fever)	Exclude until the child has received antibiotic treatment for at least 24 hours and the child feels well	Not excluded
29	Tuberculosis (excluding latent tuberculosis)	Exclude until receipt of a medical certificate from the treating physician stating that the child is not considered to be infectious	Not excluded
30	Typhoid fever (including paratyphoid fever)	Exclude until approval to return has been given by the Chief Health Officer	Not excluded unless considered necessary by the Chief Health Officer

### Regulation 111

A person in charge of a primary school, education and care service premises or children's services centre must not allow a child to attend the primary school, education and care service premises or children's services centre for the period or in the circumstances:

\* specified in column 3 of the Table in Schedule 7 if the person in charge has been informed that the child is infected with an infectious disease listed in column 2 of that Table; or

\* specified in column 4 of the Table in Schedule 7 if the person in charge has been informed that the child has been in contact with a person who is infected with an infectious disease listed in column 2 of that Table.

\*Diarrhoeal illness includes instances where certain pathogens are identified including Amebiasis (*Entamoeba histolytica*), Campylobacter spp., Salmonella spp., Shigella spp. and intestinal worms, but is not limited to infection with these pathogens.

### Further information

Please contact the Communicable Disease Prevention and Control Section on 1300 651 160 or visit [www2.health.vic.gov.au/public-health/infectious-diseases/school-exclusion](http://www2.health.vic.gov.au/public-health/infectious-diseases/school-exclusion)

<sup>1</sup> Children's services cover the terms 'education and care service premises' or 'children's services centre' used in the regulations. It includes centres such as childcare centres and kindergartens.

Name: \_\_\_\_\_ Date of birth: DD / MM / YYYY

Confirmed allergen(s): \_\_\_\_\_

Family/emergency contact(s):

1. \_\_\_\_\_ Mobile: \_\_\_\_\_

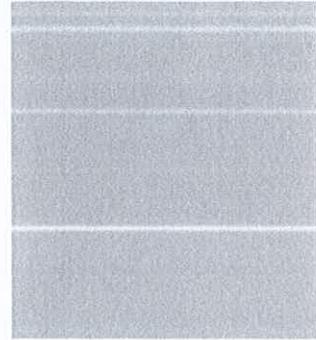
2. \_\_\_\_\_ Mobile: \_\_\_\_\_

Plan prepared by: \_\_\_\_\_ (doctor or nurse practitioner) who authorises medications to be given, as consented by the parent/guardian, according to this plan.

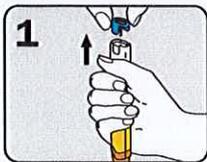
Signed: \_\_\_\_\_ Date: DD / MM / YYYY

Antihistamine: \_\_\_\_\_ Dose: \_\_\_\_\_

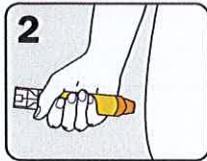
This plan does not expire but review is recommended by: DD / MM / YYYY



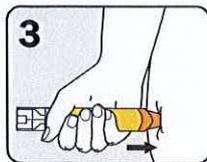
## How to give EpiPen® adrenaline (epinephrine) injector



Form fist around EpiPen® and PULL OFF **BLUE** SAFETY RELEASE



Hold leg still and PLACE **ORANGE** END against outer mid-thigh (with or without clothing)



PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds. REMOVE EpiPen®

Instructions are also on device labels. For video instructions scan this QR code:



EpiPen® is prescribed as follows:  
EpiPen® Jr (150 mcg) for children 7.5-20kg  
EpiPen® (300 mcg) for children over 20kg and adults

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

## MILD TO MODERATE ALLERGIC REACTIONS

### SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

**Mild to moderate allergic reactions may not always occur before anaphylaxis**

### ACTIONS:

- Stay with person, call for help
- Locate adrenaline injector
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

## SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

Watch for **ANY ONE** of the following signs:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)

## ACTIONS FOR ANAPHYLAXIS

### 1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



### 2 GIVE ADRENALINE INJECTOR

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

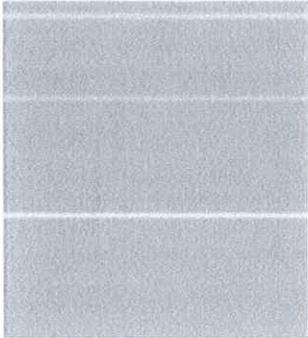
5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

### IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

**ALWAYS GIVE ADRENALINE INJECTOR FIRST, and then asthma reliever puffer** if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.



Name: \_\_\_\_\_ Date of birth: DD / MM / YYYY

Confirmed allergen(s): \_\_\_\_\_

Family/emergency contact(s):

1. \_\_\_\_\_ Mobile: \_\_\_\_\_

2. \_\_\_\_\_ Mobile: \_\_\_\_\_

Plan prepared by: \_\_\_\_\_ (doctor or nurse practitioner) who authorises medications to be given, as consented by the patient or parent/guardian, according to this plan.

Signed: \_\_\_\_\_ Date: DD / MM / YYYY

Antihistamine: \_\_\_\_\_ Dose: \_\_\_\_\_

This plan does not expire but review is recommended by: DD / MM / YYYY

This ASCIA Action Plan for Allergic Reactions is for people who have allergies but do not have a prescribed adrenaline (epinephrine) injector.

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## ACTIONS FOR ANAPHYLAXIS

### 1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



### 2 GIVE ADRENALINE INJECTOR IF AVAILABLE

- 3 Phone ambulance - 000 (AU) or 111 (NZ)
- 4 Phone family/emergency contact
- 5 Transfer person to hospital for at least 4 hours of observation

### IF IN DOUBT GIVE ADRENALINE INJECTOR

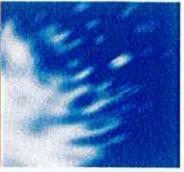
Commence CPR at any time if person is unresponsive and not breathing normally

Adrenaline injector doses are:

- 150 mcg for children 7.5-20kg
  - 300 mcg for children over 20kg and adults
  - 300 mcg or 500 mcg for children and adults over 50kg
- Instructions are on device labels.

**ALWAYS GIVE ADRENALINE INJECTOR FIRST and then asthma reliever puffer** if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.



Patient name: \_\_\_\_\_ Date: DD / MM / YYYY  
Plan prepared by: \_\_\_\_\_ Signed: \_\_\_\_\_

**ALLERGEN MINIMISATION**

- Minimising exposure to confirmed allergen/s may assist to reduce symptoms in some people. For information go to [www.allergy.org.au/patients/allergy-treatments/allergen-minimisation](http://www.allergy.org.au/patients/allergy-treatments/allergen-minimisation)

**THUNDERSTORM ASTHMA**

- Try to stay indoors just before, during and just after thunderstorms in pollen seasons if allergic to pollen. Use preventer treatments such as intranasal corticosteroid sprays or combined intranasal corticosteroid/antihistamine sprays. Consider allergen immunotherapy (see below). If you also have asthma, use asthma preventers regularly. For information go to [www.allergy.org.au/patients/asthma-and-allergy/thunderstorm-asthma](http://www.allergy.org.au/patients/asthma-and-allergy/thunderstorm-asthma)

**MEDICATIONS**

- Intranasal corticosteroid spray: \_\_\_\_\_  
 1 or  2 times/day/nostril for \_\_\_\_\_ weeks or \_\_\_\_\_ months or  continuous  
 Additional instructions: \_\_\_\_\_

or

- Combined intranasal corticosteroid/antihistamine spray:  
 1 or  2 times/day/nostril for \_\_\_\_\_ weeks or \_\_\_\_\_ months or  continuous  
 Additional instructions: \_\_\_\_\_

- Note:
- It is important to use these sprays correctly. See instructions below and directions for use.
  - Onset of benefit may take days, so these sprays must be used regularly and should not be stopped every few weeks.
  - If significant pain or bleeding occurs contact your doctor.
  - Some treatments mentioned above require a prescription.

1. Prime the spray device according to manufacturer's instructions (for the first time or after a period of non-use).
2. Shake the bottle before each use.
3. Blow nose before spraying if blocked by mucus.
4. Tilt head slightly forward and gently insert nozzle into nostril.
5. Aim the nozzle away from the middle of the nose (septum) and direct nozzle into the nasal passage (not towards tip of nose, but in line with the roof of the mouth).
6. Avoid sniffing hard during or after spraying.



- Oral non-sedating antihistamine tablet: \_\_\_\_\_ Dose \_\_\_\_\_ mL/mg  1 or  2 times/day  
 Additional instructions: \_\_\_\_\_
- Intranasal antihistamine sprays: \_\_\_\_\_  1 or  2 times/day  
 Additional instructions: \_\_\_\_\_
- Saline nasal  spray or  irrigation \_\_\_\_\_  \_\_\_\_\_ times/day or  as needed  
 Use 10 minutes prior if used with intranasal corticosteroid spray
- Decongestant: \_\_\_\_\_  nasal spray \_\_\_\_\_ times/day or  tablet  
Dose \_\_\_\_\_ tablets \_\_\_\_\_ times/day for up to three days (not more than one course/month)
- Eye drops or ointments: \_\_\_\_\_
- Other medications: \_\_\_\_\_

For information and links to animation videos go to [www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis](http://www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis)

**ALLERGEN IMMUNOTHERAPY**

If allergen immunotherapy has been initiated by a clinical immunology/allergy specialist, it is important to follow the treatment as prescribed. Contact your doctor if you have any questions or concerns. For information go to [www.allergy.org.au/patients/allergy-treatments/immunotherapy](http://www.allergy.org.au/patients/allergy-treatments/immunotherapy)

# ASTHMA ACTION PLAN

Take me when you visit your doctor

Name:

Plan date:  Review date:

Doctor details:

## EMERGENCY CONTACT

Name:

Phone:

Relationship:

Photo (optional)



### WELL CONTROLLED is all of these...

- needing reliever medicine no more than 2 days/week
- no asthma at night
- no asthma when I wake up
- can do all my activities

Peak flow reading (if used) above



#### TAKE preventer

Name

morning  night  puffs/inhalations

- Use my preventer, even when well controlled
- Use my spacer with my puffer

#### TAKE reliever

Name

puffs/inhalations as needed  puffs/inhalations 15 minutes before exercise

- Always carry my reliever medicine



### FLARE-UP Asthma symptoms getting worse such as any of these...

- needing reliever medicine more than usual OR more than 2 days/week
- woke up overnight with asthma
- had asthma when I woke up
- can't do all my activities

Peak flow reading (if used) between  and

My triggers and symptoms



#### TAKE preventer

Name

morning  night  puffs/inhalations for  days then back to well controlled dose

#### TAKE reliever

Name   puffs/inhalations as needed

#### START other medicine

Name/dose/days/other treatments

- MAKE appointment to see my doctor **same day or as soon as possible**



### SEVERE Asthma symptoms getting worse such as any of these...

- reliever medicine not lasting 3 hours
- woke up frequently overnight with asthma
- had asthma when I woke up
- difficulty breathing

Peak flow reading (if used) between  and

My triggers and symptoms



#### TAKE preventer

Name

morning  night  puffs/inhalations for  days then back to well controlled dose

#### TAKE reliever

Name   puffs/inhalations as needed

#### START other medicine

Name/dose/days/other treatments

- MAKE appointment to see my doctor **TODAY**

- If unable to see my doctor, visit a hospital

#### OTHER INSTRUCTIONS

Other medicines, treatments, dose, duration, etc



### EMERGENCY is any of these...

- reliever medicine not working at all
- can't speak a full sentence
- extreme difficulty breathing
- feel asthma is out of control
- lips turning blue

Peak flow reading (if used) below



1



#### **CALL AMBULANCE NOW**

Dial Triple Zero (000)

2



#### **START ASTHMA FIRST AID**

Turn page for Asthma First Aid

# ASTHMA FIRST AID

## Blue/Grey Reliever

Airomir, Asmol, Ventolin or Zempreon and Bricanyl

Blue/grey reliever medication is unlikely to harm, even if the person does not have asthma



**DIAL TRIPLE ZERO (000) FOR AN AMBULANCE IMMEDIATELY IF THE PERSON:**

- is not breathing
- suddenly becomes worse or is not improving
- is having an asthma attack and a reliever is not available
- is unsure if it is asthma
- **has a known allergy to food, insects or medication and has SUDDEN BREATHING DIFFICULTY, GIVE ADRENALINE AUTOINJECTOR FIRST (if available)**

1



**SIT THE PERSON UPRIGHT**

- Be calm and reassuring
- Do not leave them alone

2



**GIVE 4 SEPARATE PUFFS OF RELIEVER PUFFER**

- Shake puffer
- Put 1 puff into spacer
- Take 4 breaths from spacer
  - Repeat until 4 separate puffs have been taken



If using **Bricanyl** (5 years or older)

- **Do not shake.** Open, twist around and back, and take a deep breath in
- Repeat until 2 separate inhalations have been taken

If you don't have a spacer handy in an emergency, take 1 puff as you take 1 slow, deep breath and hold breath for as long as comfortable. Repeat until all puffs are given

3



**WAIT 4 MINUTES**

- If breathing does not return to normal, give 4 more separate puffs of reliever as above



**Bricanyl:** Give 1 more inhalation

## IF BREATHING DOES NOT RETURN TO NORMAL

4



**DIAL TRIPLE ZERO (000)**

- Say 'ambulance' and that someone is having an asthma attack
- Keep giving 4 separate puffs every 4 minutes until emergency assistance arrives



**Bricanyl:** Give 1 more inhalation every 4 minutes until emergency assistance arrives



# Epilepsy Management Plan



## 1. General information

Name of person experiencing seizures:

Date of birth:

Date to review\*:

Epilepsy/seizure diagnosis (if known):

Emergency contact details:

## 2. Tell us about any other medical conditions that might assist someone helping you.

(Examples may include intellectual disability, ASD, cerebral palsy, hydrocephalus, hypoglycaemia, FND etc.)

## 3. Tell us about any other important information that might assist someone helping you.

(Examples may include location of medical records, non-verbal, uses wheelchair, exhibits behaviours that can be mistaken for seizures, VP shunt, stimming, instructions for VNS, seizure dog etc.)

## 4. Has emergency epilepsy medication been prescribed?

Yes

No

If yes, please attach any emergency medication documentation to this plan. In the event of requiring an ambulance, please provide both of these documents to Emergency Responders. If you have been specifically trained to administer the emergency medication, please refer to the Emergency Medication Management Plan.

Where is the emergency medication located?

Client Name DOB:

**5. My seizures are triggered by:** (if not known, write no known triggers)

Blank area for recording seizure triggers.

**6. Changes in my behaviour that may indicate a seizure could occur:**

(For example pacing, sad, irritable, poor appetite, usually very mobile but now sitting quietly)

Blank area for recording changes in behaviour.

**7. My seizure description and seizure support needs:**

(Complete a separate row for each type of seizure – use brief, concise language to describe each seizure type.)

<p><b>Description of seizure</b> Describe what happens immediately before and during the seizure, signs that the seizure is resolving and if seizures occur in a cluster.</p>	<p><b>Duration &amp; Frequency</b> Describe how long seizures typically last, how frequently they occur and whether there is a noticeable pattern to your seizures.</p>	<p><b>Is emergency medication prescribed for this type of seizure?</b></p>	<p><b>When to call an ambulance</b> Consider seizure length, if occurs in water, if injury has been sustained, if breathing is affected etc. <u>If concerned at any time, call an ambulance</u></p>
<p>Blank area for seizure description.</p>	<p><b>Duration:</b></p> <p>Blank area for duration.</p> <p><b>Frequency:</b></p> <p>Blank area for frequency.</p> <p><u>OR</u> Date of last seizure:</p> <p>Blank area for date.</p> <p><b>Notable seizure pattern (if any):</b></p> <p>Blank area for pattern.</p>	<p>Yes <input type="radio"/></p> <p>No <input type="radio"/></p> <p>If <b>YES</b> and you are trained in its administration, refer to the accompanying emergency medication plan.</p> <p>If <b>not trained</b>, when calling an ambulance state that it has been prescribed.</p>	<p>Blank area for when to call an ambulance.</p>

### 8. How I want to be supported during a seizure:

Specify the support needed during each of the different seizure types.

**(If you are ever in doubt about my health during or after the seizure, call an ambulance)**

### 9. My specific post-seizure support:

State how a support person would know when I have regained my usual awareness and how long it typically takes for me to fully recover. How I want to be supported. Describe what my post seizure behaviour may look like.

### 10. My risk/safety alerts:

For example bathing, swimming, use of helmet, mobility following seizure, overnight support.

Risk	What will reduce this risk for me?

**This plan has been developed in collaboration with:**

<b>Person 1</b> Name(s):	Relationship:
Telephone number(s):	

**Others involved in plan development:**

<b>Person 2</b> Name(s):	Relationship:
Telephone number(s):	

**Endorsement by treating doctor:**

Doctor's name:	Telephone:
Signature:	Date:

**\*Date to review**

Everyone's epilepsy journey is different. It is best practice to review this plan annually to ensure relevance and currency to the individual needs. The plan should be reviewed more frequently if the person's epilepsy changes.