Flemington Primary School’s **FIRST AID POLICY & PROCEDURE** was developed from the Victorian Government School’s Reference Group and policy formulated by Flemington Primary School.

This policy was ratified in 2008, reviewed in 2014 and ratified by FPS School Council on 25<sup>th</sup> August 2014
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1. **First aid duties**
That first aid duties be organised and implemented according to school’s needs. Duties to be shared across several members of staff who have the necessary training and expertise to meet the specific requirements. First aid duties may include:
- the provision of first aid commensurate with competency and training. This may include all emergency life support, including response to life-threatening conditions that may occur in the school (for example, cardiac arrest or respiratory difficulties associated with asthma), management of severe bleeding, fractures, soft tissue injury and basic wound care
- participation in the risk management process within the school. This may include contributing to risk management solutions and providing feedback on injury reports and first aid register data to identify persistent or serious hazards
- the provision of first aid emergency awareness information for staff, including emergency notification procedures, the names of trained first aiders, and emergency services telephone numbers
- the coordination of first aid duty rosters as well as the maintenance of first aid rooms and first aid kits.

2. **First aid organisation**
That one member of staff should be allocated responsibility for the overall organisation of all first aid, sick bay supervision and the maintenance of the first aid cupboard(s) and kit(s). Desirably, this staff member should have first aid qualifications of Level 2 First Aid or its equivalent, or higher qualifications. (Note: Level 3 First Aid includes responsible administration of medications, advanced resuscitation, design, care and upkeep of first aid kits and rooms.)

Staff with current first aid qualifications should be listed with the specific type and level of first aid training, and be available to the person in charge of first aid on request or in an emergency.

All accidents and injuries are to be recorded on the injury management system on CASES21.

2.1 **Policy & Procedure**

2.1.1. All staff who have the necessary training and expertise will be rostered to be an available First Aider at lunchtime. Consideration will be given to Yard Duty rosters for those teachers rostered on as a First Aider.

2.1.2. It is the responsibility of the First Aider to be available at all times during their rostered timeslot, in the First Aid Room.

2.1.3. Recording all first aid treatment. The First Aider should respect the confidential nature of any information given;
- complete the ‘Injury Register’;
- complete the ‘Parent Notification of Accident’ form;
- complete a DE&T ‘Accident Report’ gaining as much information as possible from the injured child. If further information is required, the teacher on Yard Duty is to be contacted;
- forward the completed DE&T ‘Accident Report’ to the Office for completion on CASES21.

2.1.4. Depending on the degree of the injury, the First Aider is to contact parent / guardian, explaining the situation and requesting that the injured child be collected from school.

2.1.5. Notwithstanding the duty of care of first aiders, the treatment of illness and / or injury should be limited to those areas in which the person has received recognised training.

2.1.6. Designated first aiders shall be responsible for:
- administering the sick bay and its contents;
- monitoring patients according to their condition;
- reporting any considered hazard to the appropriate workplace Occupational Health and Safety representative and principal/manager;
- ensuring that the classroom teacher is informed of accidents that relate to a student from their class.

2.2 Yard Duty Teachers
When a student presents to the Yard Duty Teacher with an injury, the Yard Duty Teacher has three options to take, depending on the severity of the injury / illness.

Option 1: Treat the child on the spot, ie small graze which can be treated with first aid supplies in the yard duty bags.

Option 2: If the injury / illness is untreatable in the yard, or the Yard Duty Teacher is uncertain what course of action to take, the child is to be sent (escorted by a friend) to the First Aid Room with a “First Aid Required” card (found in the yard duty bags), requesting that the particular child in question is treated by the First Aider on duty.

Option 3: If it is felt by the Yard Duty Teacher that the injured / ill child is too hurt or unwell to present at the First Aid Room by themselves, the Yard Duty Teacher would send an “assistance required” card to the office.

3. First aid cabinets / kits
Although first aid cabinets normally will only be accessed by those staff with designated first aid responsibilities, all staff must be aware of its location in case of an emergency. The cabinet is to be easily recognisable and not locked. Any medications such as paracetamol, and those supplied by parents/guardians are to be stored separately in a locked cupboard or drawer.

First aid cupboard is to contain the relevant type and quantity of supplies.

The school first aid cupboard must contain:

- an up-to-date first aid book
- wound cleaning equipment
- **Gauze Swabs**: 100 of 7.5cm x 7.5cm divided into small individual packets of five
- **Sterile Saline Ampoules**: 12 x 15ml and 12 x 30ml
- **Disposable Towels**: For cleaning dirt from skin surrounding a wound

### Wound Dressing Equipment
- **Gauze Swabs**: 100 of 7.5cm x 7.5cm divided into small individual packets of five
- **Sterile, Non-Adhesive Dressings**: Individually packed: eight 5cm x 5cm, four 7.5m x 7.5m, four 10cm x 10cm for larger wounds
- **Combine Pads**: Twelve 10cm x 10cm for bleeding wounds
- **Non-Allergenic Plain Adhesive Strips**: Without antiseptic on the dressing, for smaller cuts and grazes
- **Steri-Strips**: For holding deep cuts together in preparation for stitching
- **Non-Allergenic Paper Type Tape**: Width 2.5cm–5cm, for attaching dressings
- **Conforming Bandages**: For attaching dressings in the absence of tape or in the case of extremely sensitive skin
- **Six Sterile Eye Pads**: Individually packed

### Bandages
- **Four Triangular Bandages**: For slings, pads for bleeding or attaching dressings, splints etc
- **Conforming Bandages**: Two of 2.5cm, two of 5cm, six of 7.5cm and two of 10cm. These may be used to hold dressings in place or for support in the case of soft tissue injuries

### Lotion and Ointments
- **Cuts and Abrasions**: Should be cleaned initially under running water followed by deeper and more serious wounds being cleaned with sterile saline prior to dressing.
- **Antiseptics are not recommended**
- **Any Sun Screen**: With a sun protection factor of approximately 15+
- **Single Use Sterile Saline Ampoules**: For the irrigation of eyes
- **Creams and Lotions**: Are not recommended in the first aid treatment of wounds or burns

### Asthma Equipment
- **Blue Reliever Puffer**: (e.g. Ventolin) that is in date
- **Spacer Device**: 
- **Alcohol Wipes**: 

Other equipment includes:
- **Single Use Gloves**: These are essential for all kits and should be available for teachers to carry with them, particularly while on yard duty
- **Blood Spill Kits**
- **Vomit Spill Kits**
- **One Medicine Measure**: For use with prescribed medications
- **Disposable Cups**
- **One Pair of Scissors**: (Medium size)
- **Disposable Splinter Probes and a Sharps Container for Waste**
- **Disposable Tweezers**
- **One Teaspoon**
- **Disposable Hand Towels**
two gel packs, kept in the refrigerator, for sprains, strains and bruises or disposable ice packs for portable kits
adhesive sanitary pads, as a backup for personal supplies
flexible ‘sam’ splints for fractured limbs (in case of ambulance delay)
additional 7.5 m conforming bandages and safety pins to attach splints
blanket and sheet, including a thermal accident blanket for portable kits
gemicidal soap and nail brush for hand-cleaning only
one box of paper tissues
paper towel for wiping up blood spills in conjunction with blood spill kit
single use plastic rubbish bags that can be sealed, for used swabs and a separate waste disposal bin suitable for taking biohazard waste (Note: Biohazard waste should be burnt and there are several companies that will handle bulk biohazard waste)
blanket and sheet, including a thermal accident blanket for portable kits
gemicidal soap and nail brush for hand-cleaning only
one box of paper tissues
paper towel for wiping up blood spills in conjunction with blood spill kit
single use plastic rubbish bags that can be sealed, for used swabs and a separate waste disposal bin suitable for taking biohazard waste (Note: Biohazard waste should be burnt and there are several companies that will handle bulk biohazard waste)

First aid kits are to be available for all groups that leave the school on excursions.

School is to make available portable first aid kits available for staff on yard duty. These kits should contain:
- a pair of single use plastic gloves
- a bottle of sterile eye solution
- gauze and bandaids.

4. First aid treatment
Where possible, only staff with first aid qualifications should provide first aid. However, in an emergency other staff may be required to help within their level of competency.

The first aid cabinet must contain a suitable and current first aid manual.

Each portable first aid kit is to contain a suitable first aid manual of a smaller size and, where appropriate, specialised to the activities being undertaken. Either A Quick Guide, available from St John Ambulance Australia, First aid Notes, available from Australian Red Cross, or Don't die in the Bush, available from Information Victoria, are recommended.

5. Students and medication
It is necessary that teachers, as part of their duty of care, assist students, where it is appropriate, to take their medication.

It is recommended that every student who has a medical condition or illness should have an individual written management plan that is attached to the student’s records. Desirably, each management plan should be provided by the student’s doctor and should contain details of:
- the usual medical treatment needed by the student at school or on school activities
- the medical treatment and action needed if the student’s condition deteriorates
- the name, address and telephone numbers for an emergency contact and the student’s doctor.
5.1 **Oral medication**
Parents/guardians are to supply medication in a container that gives the name of the student, the dose, and the time it is to be given. The name of the medication should be clearly marked on the container. It is recommended that parents/guardians be asked to provide a dosette box with all medication in tablet form to ensure the correct dosage is given. A dosette box is a container specifically designed to organise the dispensing of tablets.

If medication for more than one day is supplied, it is to be locked in a cupboard, located in the first aid room.

It should be noted that substances prescribed for a particular student should be retained solely for the use of that student. Only in a lifethreatening emergency would consideration be given to any variation of this requirement.

5.2 **Analgesic use**
Analgesics must only be given with the permission of parents/guardians and be issued by a designated member of staff who should maintain a record to monitor student intake. Staff should not disperse analgesics except as above.

5.3 **Medication**
5.3.1 Medication will be administered at 1.00pm daily. This will be the only time that medication will be administered.
5.3.2 All medication sent from home must be accompanied by a ‘Consent to Administer Medication Form’. Under no circumstances is medication to be administered without the ‘Consent to Administer Medication Form’ (see Appendix 7).
5.3.3 Students requiring the administering of medication, is to be called to the First Aid Room at 1.00pm.
5.3.4 If any medication is administered, a record shall be kept detailing the date, time and name of the person who administered the medication.

6. **Student Injuries / Illness**

6.1 **Treatment of Student Injuries**
6.1.1 When bathing a graze or wound, only water is to be used. At no time is an antiseptic wash to be used.
6.1.2 When providing first aid, gloves (provided by school) must be worn at all times.
6.1.3 Any **HEAD, EYES OR TEETH** injury is to be reported to the First Aider on duty. Parents are to be contacted as a courtesy in all but very minor headache “bumps”.
6.1.4 When a **HEAD** injury does occur, students must be automatically given a ‘Notice to Parents of a Head Injury’ along with the ‘Notification of Accident’ note.
6.1.5 Students requiring an ice pack on injuries are to be administered in the First Aid Room. No students are allowed to take an ice pack out to the school grounds. If required, the student may return to their classroom with the ice pack, if further treatment is required (the ice pack can be applied until the child is feeling a little more comfortable.)
6.1.6  A student who is feeling dizzy after falling and sustaining a blow to the head, for example, should not be left unsupervised. A student with a slight headache, unrelated to a recent fall or hit on the head, who is sent to lie down for a few minutes, may not require direct supervision. An attempt should be made to contact the parents/guardians before calling for medical attention except in an extreme emergency. In serious cases, parents/guardians must always be informed as quickly as possible of their child’s condition and of the actions taken by the school. Parents/guardians should be informed of any first aid emergency treatment their child has received.

6.2  **Students who become unwell during school time**

6.2.1  No student is to be sent home by the School Office until confirmation of illness has been received by the student's teacher by way of a note or message.

6.2.2  If a student presents at the School Office during recess or lunch time, saying they are feeling unwell, before a parent / guardian is contacted, the student's teacher MUST be advised of the situation.

6.2.3  Parent / guardian / emergency contacts of the ill child are to be contacted (refer to 6.2.2.).

7.  **Hygiene & Infection Control**

- All spills of bodily fluids to be mopped up with a paper towel, placed in a sealed bag along with the gloves the staff member was wearing and disposed of in a bin with a lid. (All items can be found in the blood spills kit, located in the First Aid Room).
- Gloves (provided by school) must be worn when dealing with spills of bodily fluids and spills must be cleaned up with bleach solution.
- Hands are to be washed in hot soapy water after cleaning up a spill.
- Equipment exposed to blood or bodily fluid will be cleaned in hot soapy water as soon as possible.
- Used syringes found on the premises are removed and placed in a syringe container (refer to Section 15).

8.  **Students with epilepsy**

Epilepsy is a common condition. There are numerous types of seizures associated with this condition. Seizures or convulsions can be a sudden, violent, uncontrollable contraction of a group of muscles. A seizure can also be more subtle, consisting of only a brief ‘loss of contact’ or a few moments of what appears to be daydreaming. The most common seizures experienced by children of school age will be **tonic clonic** seizures, **absence** seizures, **myoclonic** seizures and **complex partial** seizures.

For more information see either:

www.epilepsyinfo.co.uk or www.epinet.org.au

Perhaps the most dramatic seizure to witness is a tonic clonic seizure as it involves falling to the ground, tensing and clenching of muscles, followed by convulsive jerking. If a tonic clonic seizure should happen at school it is important that the teacher remains calm. Students will tend to assume the same emotional reaction as the teacher. Turn a seizure at school into a learning experience where accurate information, appropriate attitudes and understanding (not pity) are the end results.
Such an experience need not be frightening. Most children with epilepsy take anti-epileptic medication that controls their condition. Some seizures occur during or following sleep. Talking with a student’s parent/guardian will help to understand what kind of seizure a student has and how often the seizures could occur at school. Generally, it is not necessary to be over-protective of a student with epilepsy. Rather they should, as far as possible, be managed similarly to other students. Subject to medical advice, students with epilepsy should be actively encouraged to participate in swimming lessons.

8.1 First-aid for tonic clonic seizures
The following steps should be taken if a student experiences a tonic clonic seizure:

- Do not try to restrain movements or force anything between the student’s teeth.
- Stay with the student.
- Stay calm.
- Try to prevent the student from striking his/her head or body against any hard, sharp or hot object.
- Do not try to revive the student. Let the seizure run its course. Most convulsions last only a minute or two.
- As soon as possible after the seizure subsides, turn the student over onto their side with their face turned to one side and the chin extended (the recovery position) to help keep the airway open.
- Carefully observe the details of the seizure to report to medical personnel.
- On very rare occasions when a seizure continues for more than five minutes, or one seizure immediately follows another, seek medical assistance.
- Medical attention should be sought if injuries occur as a result of the seizure.
- Do not be frightened if the person in a seizure may appear momentarily not to be breathing.
- Remember that a seizure cannot hurt the onlookers. The student experiencing a tonic clonic seizure is generally, though not always, unconscious while it is happening.
- When regaining consciousness, usually within a few minutes, the student may be incoherent or very sleepy and should have the opportunity to rest. Reassure the student and tell them what has happened.
- Notify the parents/guardians or other persons responsible for the student.

8.2 First-aid for other seizures
These seizures may involve sudden, unexpected, altered levels of consciousness.
In the case of first-aid for these seizures:

- recognise that a seizure has occurred
- if the seizure involves a fall, follow the above procedure—remaining calm, protecting the student from injury, turning the student over into a recovery position, and reestablishing supportive communication
- if the seizure has involved an ‘absence’ or temporary loss of consciousness, reassure the student and repeat any information that may have been missed during the seizure
• if the student walks about, starts to undress or acts in a way that indicates they are experiencing altered consciousness, gently help the student to safety.

9. **Students with diabetes**

As far as possible, students with diabetes should be encouraged to take part fully in the total school program.

The Diabetic Clinic at the Royal Children’s Hospital has provided the following information to assist teachers with diabetic students. With appropriate preparations and safeguards, diabetic students can cope with and should participate in the full range of activities that are made available in schools, including camps and excursions. Diabetic students should not be seen to be handicapped by their condition, and should be able to cope fully with a camp program and benefit from the program to the same extent as other students. Exclusion from a camping program could be psychologically damaging for them. In general, students should be able to attend camp when they are reliably independent in their own care of diabetes. This includes an ability to:

- measure an insulin dose accurately
- inject an insulin dose reliably
- carry out blood glucose tests
- recognise the early signs of hypoglycaemic reactions and to take sugar when they occur
- estimate their diet in portions
- understand the need to take extra food before increased physical activity
- have meals and snacks on time.

In some circumstances, a parent/guardian might accompany the staff of the camp to assist with a student who is not fully independent, or the staff of a camp might take special responsibilities if a student is not yet reliably independent. This is to be encouraged if the student requires it, but discouraged if the child is reliable without supervision.

A student must take adequate supplies of insulin, disposable syringes or pen injector devices, blood testing equipment, and glucose or suitable sugar products to prevent or treat an insulin reaction.

Whether these are kept by the student or are handed to the teacher should be by mutual agreement between parents/guardians, student and teacher. In many instances, it would be most appropriate for the students to keep their own insulin and syringes to save embarrassment and because of the self-reliance that most students with diabetes develop. It is essential that blood glucose testing equipment and sugar be kept with the student to be available when needed. It is desirable that a student’s friends be aware of the student’s diabetes to give moral support if needed, to save embarrassment at blood testing and insulin giving times, and to give appropriate help if needed should the student have an insulin reaction. Students in the same bedroom or tent should be aware of a student’s diabetes, but it is undesirable to inform all the camp group as this may cause undue attention to be placed on the student.

In general, the student should undertake all camp duties and activities. However, some free time before breakfast and before the evening meal will be needed for blood testing and insulin injections, and before bed for urine testing. It may be
necessary to provide some private place for a student to administer the insulin, although many students give it in the sleeping quarters without embarrassment. Meal times should be adhered to as closely as possible. If a meal is delayed, the student should have access to food containing some complex carbohydrate (for example, fruit, biscuits, fruit juice) at the normal meal time while waiting for the meal. A diabetic student should be permitted to take extra food at odd times before extra physical activities to prevent insulin or hypoglycaemic reactions. On any excursion beyond the camp site, the student or teacher must take some extra carbohydrate form of food or confectionery. A school camp might be considered unsuitable for a diabetic student if medical aid is not available within approximately two hours in an emergency. Under these circumstances, unless a staff member is familiar with emergency safety procedures, the student should not attend such a camp.

9.1 **Low Blood Sugar Symptoms (HYPOGLYCAEMIA)**
- Sweating
- Weakness
- Hunger
- Weeping
- Paleness
- Drowsiness
- Trembling
- Irritability
- Inability to think straight
- Change in mood/behaviour
- Lack of co-ordination

9.2 **Emergency Action** – any one of the following
- 4 large jelly beans
- 1/2 - 1/3 glass of fruit juice
- 2 - 3 teaspoons of honey
- 2 – 3 teaspoons of sugar
- 1/3 – 1/2 can of soft drink

9.3 **Severe “Hypo”**
- Recognise when the child is unable to swallow and instigate first aid
- Coma position
- Keep airway clear
- Stay with the child
- Call an ambulance
- Have the office contact parents

**IF IN DOUBT – TREAT**

10. **Students with Asthma**

10.1 **Asthma Awareness**
Students with asthma have sensitive airways in their lungs. When exposed to certain triggers their airways narrow, making it hard for them to breathe. It is important that all school staff are aware of how to assess and manage an asthma emergency and the importance of daily asthma management.
Symptoms of asthma commonly include:
- Cough
- Tightness in the chest
- Shortness of breath/rapid breathing
- Wheeze (a whistling noise from the chest)

Many children and adolescents have mild asthma with very minor problems and rarely need medication. However, some students will need medication on a daily basis and frequently require additional medication at school (particularly before or after vigorous exercise). Most students with asthma can control their asthma by taking regular medication.

10.2 Asthma Medication
There are three main groups of asthma medications: relievers, preventers and symptom controllers. There are also combination medications containing preventer and symptom controller medication in the same delivery device.

Reliever medication provides relief from asthma symptoms within minutes. It relaxes the muscles around the airways for up to four hours, allowing air to move more easily through the airways. Reliever medications are usually blue in colour and common brand names include Airomir, Asmol, Bricanyl, Epaq and Ventolin. They should be easily accessible to students at all times, preferably carried by the student with asthma. All students with asthma should be encouraged to recognize their own asthma symptoms and take their blue reliever medication as soon as they develop symptoms at school. Blue reliever medications should be the only ones used during the school day unless a parent/carer has advised otherwise.

Preventer medications come in autumn colours (for example brown, orange, yellow) and are used on a regular basis to prevent asthma symptoms. They are mostly taken twice a day at home and will generally not be seen in the school environment.

Symptom controllers are green in colour and are often referred to as long acting relievers. Symptom controllers are used in conjunction with preventer medication and are taken at home once or twice a day. Symptom controllers and preventer medications are often combined in one device. These are referred to as combination medications and will generally not be seen at school. Although preventers, symptom controllers and combination medications will not be seen on a daily basis at school, they may be used on camp and overnight excursions and staff may need to assist or remind a student to take them under advice from the parent/carer (see Section 10.11 - Asthma at Camps and Overnight Excursions).

Parents/carers are responsible for ensuring that their children have an adequate supply of the appropriate medication at school and that it is labelled with the name of the student and parent/carer contact details. It is also recommended that parents/carers provide a spacer at school for their child’s individual use where appropriate. It is necessary that staff, as part of their duty of care, assist students with asthma, where appropriate, to take their own medication.
10.3 **Asthma Medication Delivery Devices**  
Asthma medications are generally taken by a hand-held inhaler device such as a ‘puffer’ (metered dose inhaler) or dry powder inhaler (turbuhaler, accuhaler, aerolizer). It is recommended that a puffer be used in conjunction with a spacer device to assist with fast and more effective delivery of medication. A spacer is an inexpensive device that assists in the effective administration of medication, ensuring that the inhaled medication (both reliever and preventer) gets into the airways. Note: School is to provide a blue reliever puffer (for example Airomir, Asmol, Epaq or Ventolin puffer) and a matching spacer device in the school’s First Aid Kit (see section 3 - First Aid Cabinets/Kits and section 10.6 Cleaning of Delivery Devices).

10.4 **School Asthma Action Plans**  
Every student with asthma attending the school is to have a written Asthma Action Plan, ideally completed by their treating doctor or paediatrician, in consultation with the student’s parent/carer. This is to be attached to the student’s records and updated annually or more frequently if the student’s asthma changes significantly. The Asthma Action Plan should be provided by the student’s doctor and be easily accessible to all staff. Staff should identify high-risk asthma students and ensure that their Asthma Action Plan is updated regularly. If a student is obviously and repeatedly experiencing asthma symptoms and/or using an excessive amount of reliever medication, the parents/carers should be notified so that appropriate medical consultation can be arranged.

When a student attends a camp, their asthma may require different management and so it is recommended that schools use the Camp Asthma Action Plan (see Section 10.11 - Asthma at Camps and Overnight Excursions).

The Asthma Action Plan will include:
- Usual medical treatment (medication taken on a regular basis when the student is ‘well’ or as premedication prior to exercise – see Section 10.10 - Exercise Induced Asthma)
- Details on what to do and details of medications to be used in cases of deteriorating asthma. This should include how to recognize worsening symptoms and what to do during an acute asthma attack. The Asthma First Aid section of the Asthma Action Plan must have no less than 4 separate puffs of blue reliever medication every 4 minutes. If the Asthma Action Plan is returned with **less** than the required number of puffs per minute the plan must be sent back to the parent/carer and doctor for review. **If a student’s Asthma Action Plan is unavailable use the 4 Step Asthma First Aid Plan (see Section 10.8 - Asthma First Aid).**
- Name, address and telephone number of an emergency contact
- Name, address and telephone number (including an after-hours number) of the student’s doctor.

A School Asthma Action Plan should be offered annually to parents/carers whose children have asthma. It is the parent/carer’s responsibility to convey clear instructions from the doctor to the school about the student’s asthma medication requirements.
10.5 Supplementary First Aid Supplies
As well as ready access to the details of each student’s Asthma Action Plan (usual treatment and first aid), it is essential to have equipment for managing an asthma emergency available in school’s First Aid Kit.

The asthma emergency kit must include:

- **A blue reliever puffer** (for example Airomir, Asmol, Epaq or Ventolin). Blue reliever puffers in the asthma emergency kit are for First Aid use only. Students should provide their own medication for their usual asthma management although the spacer device from the asthma emergency kit can be used with the student’s own medication.

- **A spacer device** to assist with effective inhalation of the blue reliever medication, for example a Volumatic, Able Spacer or Breath-a-Tech. Consult a pharmacist about matching the spacer with the reliever puffer.

- **Clear, written instructions** on how to use these medications and devices, plus the steps to be taken in treating an acute asthma attack as described in Section 10.8 - Asthma First Aid.

- **70% alcohol swabs** e.g. Medi-Swab™ to clean devices after use (see 10.6 - Cleaning of Delivery Devices). Schools can legally purchase a blue reliever puffer for First Aid purposes from a pharmacist on written authority of the Principal. The First Aid Co-ordinator has the responsibility of regularly checking the expiry date on the canister of the reliever puffer and the amount of medication left in the puffer.

10.6 Cleaning of Delivery Devices
Devices (for example, puffers and spacers) that are used by more than one person must be cleaned thoroughly after each use to prevent crossinfection. Devices can be easily cleaned by following these steps (Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the Health Care Setting, Department of Health & Ageing, Canberra, 2004):

- Ensure the canister is removed from the puffer container (the canister must not be submerged) and the spacer is separated into two parts.
- Wash devices in hot water and kitchen detergent.
- Do not rinse.
- Allow devices to ‘air dry’. Do not rub dry.
- When dry, wipe the mouthpiece thoroughly with a 70% alcohol swab. e.g. Medi-Swab™
- When completely dry, ensure the canister is replaced into the puffer container and check the device is working correctly by firing one or two ‘puffs’ into the air. A mist should be visible upon firing.
- If any device is contaminated by blood, throw it away and replace the device.
- Ensure the devices are stored in a dustproof container, as hygienically as possible.

10.7 Assessment and First Aid Treatment of an Asthma Attack
If a student develops signs of what appears to be an asthma attack, appropriate care must be given immediately.

10.7.1 Assessing the severity of an asthma attack
Asthma attacks can be:
- **Mild** - this may involve coughing, a soft wheeze, minor difficulty in breathing and no difficulty speaking in sentences
- **Moderate** - this may involve a persistent cough, loud wheeze, obvious difficulty in breathing and ability to speak only in short sentences
- **Severe** - the student is often very distressed and anxious, gasping for breath, unable to speak more than a few words, pale and sweaty and may have blue lips.

All students judged to be having a severe asthma attack require emergency medical assistance. Call an ambulance (dial 000), notify the student’s emergency contact and follow the 4 Step Asthma First Aid Plan while waiting for the ambulance to arrive. When calling the ambulance state clearly that a student is having ‘breathing difficulties.’ The ambulance service will give priority to a person suffering extreme shortness of breath. Regardless of whether an attack of asthma has been assessed as mild, moderate or severe, Asthma First Aid (as detailed below) must commence immediately. The danger in any asthma situation is delay. Delay may increase the severity of the attack and ultimately risk the student's life.

### 10.8 Asthma First Aid

If the student has an Asthma Action Plan follow the first aid procedure immediately. If no Asthma Action Plan is available the steps outlined below should be taken immediately. The Asthma First Aid procedure is to be clearly displayed in the staff room so that all staff are familiar with them. Asthma First Aid poster/s are to be displayed in the sick bay. Asthma First Aid instructions must be written on a card in the asthma emergency kit.

If the student’s own blue reliever puffer is not readily available, one should be obtained from the asthma emergency kit or borrowed from another student or staff member and given without delay. It does not matter if a different brand of reliever medication is used.

#### The 4 Step Asthma First Aid Plan

**Step 1**  
Sit the student down in as quiet an atmosphere as possible. Breathing is easier sitting rather than lying down. Be calm and reassuring. Do not leave the student alone.

**Step 2**  
Without delay give 4 separate puffs of a blue reliever medication (*Airomir*, *Asmol*, *Epaq* or *Ventolin*). The medication is best given one puff at a time via a spacer device. If a spacer device is not available, simply use the puffer on its own. Ask the person to take 4 breaths from the spacer after each puff of medication.

**Step 3**  
Wait 4 minutes. If there is little or no improvement repeat steps 2 and 3.

**Step 4**  
If there is still little or no improvement; call an ambulance immediately (dial 000). State clearly that a student is having ‘breathing difficulties.’

Continuously repeat steps 2 and 3 while waiting for the ambulance.
If at any time the student’s condition suddenly worsens, or you are concerned, call an ambulance immediately.

Contact the student’s parent/carer and doctor immediately, after calling the ambulance.

The incident must be recorded if the 4 Step Asthma First Aid Plan is used. Even if the student has a complete recovery from the asthma attack, do not leave them alone.

Blue reliever puffers are safe. An overdose cannot be given by following the instructions outlined. However, it is important to note that the student may experience harmless side effects such as shakiness, tremor or a ‘racing’ heart.

10.9 First Attack of Asthma
A problem that may be encountered is when a student is having difficulty breathing at school and is not known to have pre-existing asthma. In this situation administer 4 separate puffs of a blue reliever puffer via a spacer and call an ambulance immediately. Keep giving 4 separate puffs of a blue reliever puffer via a spacer every 4 minutes until the ambulance arrives. This treatment could be life saving for a student whose asthma has not been previously recognised and it will not be harmful if the breathing difficulty was not due to asthma.

Blue reliever puffers are extremely safe even if the student does not have asthma.

10.10 Exercise Induced Asthma (EIA)
Students with asthma should be encouraged to participate in all school activities, including sport and fitness. The only form of exercise that is not recommended for people with asthma is SCUBA diving. However, exercise (particularly strenuous and endurance exercise such as cross country running) can trigger an asthma attack in many children with asthma.

EIA may vary considerably from day to day and can be particularly troublesome when the student has a cold or flu, is recovering from a recent flare-up of asthma, during cold weather or in unsuitable conditions such as high pollution or high pollen days. If a student’s asthma has recently flared up, it may be suitable for the student to abstain from activities until they recover.

In many instances, EIA comes on soon after completion of the activity when the student is ‘cooling down,’ rather than during activity. Frequent EIA is likely to occur when inadequate preventer medication is being used and if this is occurring, the parent/carer should be advised to seek medical guidance about their child’s asthma.

10.10.1 Prevention
EIA can often be prevented by a simple warm-up period and premedicating with a blue reliever puffer and/or other medication as recommended by the treating doctor, at least 5-10 minutes before exercise. A simple cool down period is recommended after exercise. Obtaining better overall control of the student’s asthma with long-term preventative treatment also reduces the likelihood of EIA. If the student’s asthma has been unstable or
they have been unwell it is recommended that they avoid exercise until their asthma stabilises.

10.10.2 Treatment
If students develop EIA, they should immediately cease exercise, rest and take reliever medication. If all symptoms disappear they may be able to resume their exercise program. However, if symptoms persist, worsen or reappear, the asthma attack needs to be managed as outlined in Section 10.8 - Asthma First Aid, and the student must not return to exercise. Even if the student responds the second time to the reliever medication, he/she should not resume exercise that day.

10.11 Asthma at Camps and Overnight Excursions
If students are going away overnight the accompanying staff must:
- Take the appropriate number of asthma emergency kits
- Take extra information away with them about the student’s asthma (e.g. Camp Asthma Action Plan available from The Asthma Foundation or download from http://www.asthma.org.au/). (Refer to Appendix 8.)
- Check the parent/carer has given their child enough medication for the period, including preventer medication if required.
- If staff and students are going to a remote setting call The Asthma Foundation for advice and appropriate training.

10.12 Evacuation
All schools are required to develop and maintain an emergency management plan, which should include procedures to be followed in case of an evacuation. In the event of an evacuation, school is to ensure that a nominated staff member collects an asthma emergency kit together with student Asthma Action Plans in case breathing difficulties occur during evacuation.

The Asthma Foundation of Victoria provides education, training and resources for students and school staff on managing asthma at school. For information on the Asthma Friendly® Schools Program call (03) 9326 7088 or 1800 645 130.
Email: schools@asthma.org.au
Web: Asthma Foundation

10.13 Policy
- That parents / guardians of students that suffer from Asthma complete a ‘School Asthma Management Plan” (refer to Appendix 9), which is kept on file at school.
- Junior students (ie Prep to Grade 1) leave their ventolin and / or spacer, packaged and labelled at the school office. If ventolin is required, office staff will be able to assist the child in administering the medication as per their “School Asthma Management Plan”.
- Middle and Senior Grades keep their ventolin in their bags to self-administer when required.
- As a courtesy, the parent / guardian is to be contacted by the First Aid Officer and advised of the administering of asthma medication.
11. Infectious Diseases

11.1 Exclusions from school
Principals are required to exclude students according to the School Exclusion table under the Health (Infectious Diseases) Regulations 2001. A current version of this table is available at: www.health.vic.gov.au/ideas/regulations/id_regs.htm (refer to Appendix 2)

Note: The regulations require the parent/guardian to inform the principal as soon as practicable if the child is infected with any of the diseases listed in the table, or has been in contact with an infected person. It should be noted that in cases of diphtheria, typhoid and paratyphoid fever, exclusion and determination of recovery will be matters for the municipal medical officer of health.

‘Contact’ means child of school age or preschool age living in the same house as the patient or who has been in association with an infected person or a contaminated environment.

‘Medical Certificate’ means a certificate of a registered medical practioner.

‘Patient’ includes carrier.

‘School’ includes any preschool centre, kindergarten, primary or secondary school.

Patients or contacts shall be prevented from attending school unless they comply with the conditions hereunder prescribed.

It should be noted that during outbreaks of diseases prescribed in the table principals are to direct parents/guardians of students who are not immunized to keep their children at home for the recommended period.

Further information can be obtained from: www.eduweb.vic.gov.au/hrweb/ohs/health/healthd.htm

12. Head lice (pediculosis) control
Students with head lice have been found in most Victorian schools. Head lice are only passed on through direct hair-to-hair contact with another person who has head lice.

These insects are up to 2 mm long and lay their eggs (nits) on hair close to the scalp, primarily at the back of the neck and behind the ears. Eggs are up to 1 mm in length, oval in shape, off-white in colour and are cemented to the hair. Egg cases that remain once the lice have hatched are dull white and generally found on shafts of hair further than 1 cm from the scalp.

12.1 School Policy
Please refer to Appendix 3.

12.2 Head Lice Inspections at school - written parental consent
The Department of Education and Training has advised that informed written consent by the parent/guardian must be obtained prior to any student being inspected for the presence of head lice. (Refer to Appendix 4).
The consent form is to be signed when the student commences school. This will provide permission for the child to be inspected for head lice, and cover the duration of their schooling at the school. This form is available in 21 languages from the Department’s Sofweb website at: www.sofweb.vic.edu.au/wellbeing/headlice/consent_form.htm

12.3 Visual Checks
Persons authorised by the school principal, e.g. classroom teachers, are now encouraged to visually check each student’s hair for the presence of head lice, when it is suspected that head lice may be present. No physical contact with the student must occur during a visual checks.

Differences between Head Lice Inspections and Visual Checks

<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
<th>Authorised Persons</th>
<th>Parent Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Lice Inspections</td>
<td>Examinations of a child head for the presence of head lice.</td>
<td>Persons authorised by the school principal and school council, e.g. school nurse, parent volunteer.</td>
<td>Parental consent is required (obtained upon child’s enrolment at a school).</td>
</tr>
<tr>
<td>Visual Checks</td>
<td>Observations without physically touching a student’s head.</td>
<td>Persons authorised by the school principal e.g. classroom teacher.</td>
<td>No parental consent required.</td>
</tr>
</tbody>
</table>

12.4 Exclusion
The responsibility to exclude a child from a school rests with the principal. Principals must exclude infected students (according to the Health (Infectious Diseases) Regulations 2001) until the day after appropriate treatment has commenced. A student with head lice can be treated one evening and return to school the next day. School is to be aware that exclusion only refers to those children who have live head lice and does not refer to head lice eggs. The presence of eggs in the hair is not cause for exclusion.

The Department of Human Services recommends that at the conclusion of the school day, the child should be provided with a note to take home to inform the parent that their child may have head lice. Children may return to school after treatment has commenced.
There is no requirement in the Health (Infectious Diseases) Regulations 2001 for a clearance certificate to be issued either by a general practitioner or a municipal council.

12.5 Detection; Treatment and Notification
The responsibility for the detection and treatment of head lice rests primarily with parents. It is important that parents are supported and provided practical advice on how to treat head lice in partnership with School and the Department.
The discovery of head lice can be a stressful situation. School is to exercise sensitivity towards this issue and to avoid any stigmatisation by maintaining student confidentiality.

It is recommended that:

- The parent/guardian/ carer regularly (preferable once a week) inspect their child’s hair to look for lice or eggs, and regularly inspect all household members and then treat them if necessary.
- The parent/guardian/carer notify school if their child is affected and advise school when treatment has started and notify parents or carers of their child’s friends so they too have the opportunity to detect and treat their children if necessary.
- The parent/guardian/ carer does not send their child to school with untreated head lice.
- The principal, on being told of the infestation of a student, should alert parents/guardians, particularly those of other students in the same class. It is not advocated that the Principal inform the whole school community each time head lice is detected. The Department of Human Services indicate that most schools will have students with head lice at any one time. With this in mind, a school could theoretically alert the whole school community every day of the school year, which could in turn, create a perception of pseudo outbreak of a school being riddled with head lice. Principals should therefore use discretion if wishing to alert the school community about the infestation of head lice.

12.6 Resources
Education of parents/guardians/carers about head lice, their recognition and treatment can be obtained through the Department of Human Service’s website at: www.health.vic.gov.au/headlice

The following resources are components of a Head Lice Management Toolkit available at:

13. Parvovirus B19 (‘slapped cheek’)
Slapped cheek disease, also known as ‘fifth disease’ or ‘erythema infectiosum’ is a common childhood viral infection caused by human parvovirus B19. The illness starts with a low grade fever followed by a characteristic bright red rash on the cheeks (hence ‘slapped cheek’) and finally a fine, red lace-like rash over the rest of the body that fades but may recur over several weeks on exposure to heat. Adults often have little rash but may have joint aches and pains that are sometimes prolonged. In rare cases, infection during pregnancy can cause a fatal form of anaemia in the unborn child. Parvovirus infection does not cause congenital abnormalities.

The virus is spread mostly by respiratory droplets. When an infected person coughs or sneezes, the virus can be quickly spread to others. However, once the rash is present, the person is usually no longer infectious and need not be isolated.

The treatment is supportive only. Fluids, something to reduce the fever (i.e. paracetamol) and rest are important. Antibiotics are of no use since it is a viral illness. The best control measure is to re-emphasise the need for strict hygiene in
dealing with respiratory secretions (disposable tissues and a process for dealing with disposal of tissues, hand washing, no sharing of drinking utensils etc) and good cleaning procedures.

If there is an outbreak of this virus within the school, information should be circulated regarding the risks of transmitting and acquiring the infection. In particular, people who are at risk of potentially serious complications from parvovirus should be alerted and advised to avoid contact with infectious cases. These include:
- parents, members of staff or students who have suppressed immune systems or who have chronic haemolytic disorders
- all pregnant parents or staff members.

Further information can be obtained from the following websites:

14. **Cleaning and removal of blood spills**

   **Equipment:**
   - single-use gloves
   - paper towels
   - single-use plastic bags
   - warm water and detergent.

   **Procedure:**
   - put on gloves
   - use paper towels to mop up the blood spill and dispose of them into a plastic bag
   - wash area with warm water and detergent, rinse and dry
   - place gloves into plastic bag
   - seal bag and dispose of it in a rubbish bin
   - wash hands in warm soapy water and dry thoroughly
   - if re-usable items/utensils are used rinse with cold water, wash in warm soapy water, rinse in hot water and dry.

15. **Safe disposal of discarded needles**

   School must have an approved disposal container for discarded needles, located in the First Aid Room.

   **Equipment and procedures for the safe disposal of discarded needles and syringes are detailed below.**

   **Equipment:**
   - single-use gloves
   - plastic bags
   - if an approved disposal container is not available then use a hardwalled container. Do not use glass bottles as they can break.

   **Procedure:**
   - put on single-use gloves
   - never recap the needle even if the cap is also discarded
   - place the disposal container on the ground next to the syringe
   - pick up the syringe as far from the needle end as possible by the barrel (plastic end). Do not pick it up by the needle end. Make sure the needle is pointing away from you
16. **Needle stick injuries**

Research has indicated that the risk of infection from needle stick injury is low and should not cause alarm (Victorian Infectious Diseases Bulletin, Vol. 12, Issue 4, November 1999, page 72).

The following procedures should be observed in case of a ‘sharps’ or an exposure ‘needle stick’ injury:

- flush the injured area with flowing water
- wash the affected part with warm, soapy water and pat dry
- cover the wound with a waterproof dressing
- report the injury to the principal
- see a doctor as soon as possible for an assessment of the risk of infection and appropriate treatment.

If the needle and syringe cannot be retrieved, mark the area so that others are not at risk and contact the Syringe Disposal Helpline on 1800 552 355.

17. **Skin protection**

Australia has the highest incidence of skin cancer in the world, with one in two Australians developing some form of skin cancer during their lifetime. Exposure to the sun during childhood and adolescence is known to be a major cause of skin cancer.

17.1 **Policy**

Refer to Appendix 6 – Flemington Primary School's Sunsmart Policy.
18. School health and dental services

18.1 School health assessments

School nursing staff from the Department of Human Services conduct health assessments of Prep students in government schools. The nurses also:

- accept referrals by parents/guardians, teachers and children where a student has health/welfare problems
- refer students with health problems to their doctor or other appropriate agency, with the written permission of parents/guardians
- review students referred for action who have special needs, or with borderline results from a previous examination.

18.2 School dental services

The School Dental Service provides regular dental care for all primary school children, and concession card holders and their dependants in Years 7 and 8. Services are provided at either a mobile dental van located in the school grounds or at a nearby community dental clinic.

Care is offered for twelve to twenty-four months, depending on treatment needs.

Emergency dental care is generally assessed within twenty-four hours of making contact with dental staff (during clinic business hours).

The Royal Dental Hospital provides emergency care outside normal hours, from 5.30 pm to 9.15 pm weekdays and from 8.45 am to 9.15 pm on weekends and public holidays.

The service promotes the dental health of students to enable them to maintain healthy teeth for life. Dental therapists working under the general supervision of dentists provide dental examinations, dental health education and promotion, and preventive dental care. Of particular importance is the use of dental sealants. These protective coatings are placed in the susceptible grooves of the back molar teeth to prevent decay. Fillings and extractions are also provided when required.

The student’s parent/guardian must sign a consent form prior to an examination being provided.

Resources can be accessed by teachers for planning and conducting dental health education in the school.

All enquiries can be directed to the Oral Health Promotion Unit, Royal Dental Hospital of Melbourne, 720 Swanston Street, Melbourne, telephone 9341 1000.

18.3 School dental services expansion

School dental care has been extended to include the dependents of concession card holders up to Year 12.

18.3.1 Youth Dental Program

The Youth Dental Program provides regular dental care for concession card holders and their dependants in Years 9 to 12 and for
school leavers under eighteen years of age. Care is provided at local community dental clinics.

Costs of School Dental Service and Youth Dental Program Public dental care is provided free of charge to children under eighteen years of age who are concession card holders or dependants of concession card holders.

For primary school children who are not concession card holders or dependants, a fee of $25 covers a dental examination and dental treatment required for a course of care (except orthodontics), up to a maximum charge of $100 per family for course of care. Referrals to specialists can be organised. For further information telephone 1300 360 054.

19. **Students who are at risk of anaphylaxis (severe allergies)**

**What is anaphylaxis?**

Anaphylaxis is a severe, rapidly progressive allergic reaction that is potentially life threatening. Although allergic reactions are common in children, severe life-threatening allergic reactions are uncommon and deaths are rare. However, deaths have occurred and anaphylaxis must therefore be regarded as a medical emergency requiring a rapid response.

**What are the main causes?**

Research shows that students in the 10-18 year age group are at greatest risk of suffering a fatal anaphylactic reaction[1]. Certain foods and insect stings are the most common causes of anaphylaxis. Eight foods cause ninety-five per cent of food allergic reactions in Australia and can be common causes of anaphylaxis:

- peanuts;
- tree nuts (i.e. hazelnuts, cashews, almonds, walnuts, pistachios, macadamias, brazil nuts, pecans, chestnuts and pine nuts);
- eggs;
- cow’s milk;
- wheat;
- soy;
- fish and shellfish (e.g. oysters, lobsters, clams, mussels, shrimps, crabs and prawns); and
- sesame seeds.

Other common allergens include some insect stings, particularly bee stings but also wasp and jumper jack ant stings, tick bites, some medications (e.g. antibiotics and anaesthetic drugs) and latex.

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Flemington PS has an anaphylaxis Policy in place that meets Ministerial Order 706 by providing the following information:

1. The school First Aid Procedure and emergency response procedures;
2. Individual Anaphylaxis Management Plans for affected students;
3. ASCIA Plans for affected students as provided by the treating General Practitioner;
4. Prevention Strategies for in school setting and out of school settings;
5. Communication plans for the school;
6. Training for staff;
7. Completion of an Annual Risk Management Checklist

19.1 Anaphylaxis Training Requirements

The following School Staff must be trained and briefed:

- those who conduct classes that students with a medical condition relating to allergy and the potential for anaphylactic reaction attend; and
- any further School Staff that the Principal identifies, based on an assessment of the risk of an anaphylactic reaction occurring while a student is under the care or supervision of the School.

The required training includes:

1. An Anaphylaxis Management Training Course in the previous three years conducted by an external training provider (St Johns offer training for DEECD Schools); and
2. Participate in a briefing, to occur twice each calendar year, with the first briefing to be held at the beginning of the school year, on:
   - the School's Anaphylaxis Management Policy;
   - causes, symptoms and treatment of anaphylaxis;
   - the identities of students diagnosed with a medical condition that relates to allergy and the potential for anaphylactic reaction and where their medication is located;
   - how to use an Adrenaline Autoinjector, including hands on practise with a trainer Adrenaline Autoinjector;
   - the School's general first aid and emergency response procedures; and
   - the location of, and access to, Adrenaline Autoinjectors that have been provided by Parents or purchased by the School for general use.

The briefing must be conducted by a member of the School Staff who has current anaphylaxis training. For the purposes of these Guidelines, and the Order, this means that the member of the School Staff has successfully completed an Anaphylaxis Management Training Course in the previous 12 months.

19.2 Signs and symptoms

19.2.1 Mild to moderate allergic reaction can include:
- swelling of the lips, face and eyes;
• hives or welts;
• tingling mouth; and
• abdominal pain and/or vomiting (these are signs of a severe allergic reaction to insects).

19.2.2 Anaphylaxis (severe allergic reaction) can include:
  o difficult/noisy breathing;
  o swelling of tongue;
  o swelling/tightness in throat;
  o difficulty talking and/or hoarse voice;
  o wheeze or persistent cough;
  o persistent dizziness or collapse; and
  o pale and floppy (young children).

Symptoms usually develop within 10 minutes to several hours after exposure to an allergen, but can appear within a few minutes.

19.3 Treatment of anaphylaxis

Adrenaline given as an injection into the muscle of the outer mid-thigh is the most effective first aid treatment for anaphylaxis. Children diagnosed as being at risk of anaphylaxis are prescribed Adrenaline Autoinjector in an emergency. The two most common brands of Adrenaline Autoinjectors available in Australia are EpiPen® and Anapen®300. Children between 10 and 20 kilograms are prescribed a smaller dosage of adrenaline, through an EpiPen®Jr or Anapen®150. These Adrenaline Autoinjectors are designed so that anyone can use them in an emergency.

19.4 Students at risk of anaphylaxis

• A member of the School Staff should remain with the student who is displaying symptoms of anaphylaxis at all times. As per instructions on the ASCIA Action Plan: ‘Lay the person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.’
• A member of the School Staff should immediately locate the student’s Adrenaline Autoinjector (EpiPen) and the student’s Individual Anaphylaxis Management Plan, which includes the student’s ASCIA Action Plan.
• Send someone to school office with student medical card (if available) to notify the Office.
• School office to send an adult to Mt Alexander Road to signal the ambulance.
• Parents to be notified.

19.5 Location of the Epipens

• Epipens (supplied by the afflicted child) are located in the school office.
• If on Yard duty or in specialist room (Music; Italian, Art/Science) send red EpiPen card to office and EpiPen will be brought to child.
• Epipen card are located on wall in specialist room and in Yard Duty Bag.
19.6 How to administer the EpiPen

1. Remove from plastic container.
2. Form a fist around EpiPen® and pull off the blue safety cap.
3. Place orange end against the student's outer mid-thigh (with or without clothing).
4. Push down hard until a click is heard or felt and hold in place for 10 seconds.
5. Remove EpiPen®.
6. Massage injection site for 10 seconds.
7. Note the time you administered the EpiPen®.
8. The used autoinjector must be handed to the ambulance paramedics along with the time of administration.

19.7 Further Information

Organisations providing information and resources:

- **Australasian Society of Clinical Immunology and Allergy** (ASCIA) provide information on allergies. ASCIA anaphylaxis e-training provides ready access to anaphylaxis management education throughout Australia and New Zealand, at no charge. The child care versions of the courses, incorporating training in the use of the Adrenaline Autoinjector devices Epipen® and Anapen®, have been approved by ACECQA for the purposes of meeting the requirements of the National Regulations. Further information is available at: [http://www.allergy.org.au/](http://www.allergy.org.au/)

- **ANAlert** is a free alert service that sends reminders to replace an Anapen® before it expires, helping to ensure it is within its 'use by' or 'expiry date'. ANAlert can be accessed at: [http://www.analert.com.au](http://www.analert.com.au)

- **EpiClub** provides a wide range of resources and information for managing the use and storage of the Adrenaline Autoinjector device Epipen®. They also provide a free service that sends a reminder by email, SMS or standard mail prior to the expiry date of an EpiPen®. Further information is available at: [www.epiclub.com.au](http://www.epiclub.com.au)

- **Allergy & Anaphylaxis Australia** is a non-profit organisation that raises awareness in the Australian community about allergy. A range of items including children’s books and training resources are available from the online store on the Allergy & Anaphylaxis Australia website. Further information is available at: [http://www.allergyfacts.org.au/allergy-and-anaphylaxis](http://www.allergyfacts.org.au/allergy-and-anaphylaxis)

- **Royal Children's Hospital Anaphylaxis Advisory Line** provides advice and support on implementing anaphylaxis legislation to education and care services and Victorian children's services. The Anaphylaxis Advisory Line is available between the hours of 8:30 a.m. to 5:00 p.m., Monday to Friday. Phone 1300 725 911 (toll free) or (03) 9345 4235. Further information is available at: [http://www.rch.org.au/allergy/advisory/anaphylaxis_Support_advisory_line/](http://www.rch.org.au/allergy/advisory/anaphylaxis_Support_advisory_line/)

- **Royal Children's Hospital, Department of Allergy and Immunology** provide information about allergies and the services provided by the hospital. Further information is available at: [http://www.rch.org.au/allergy/](http://www.rch.org.au/allergy/)
A GUIDE TO CALLING AN AMBULANCE

In the event of an Anaphylaxis reaction or other serious injuries

Dial 000. Ask for ambulance.

1. Be prepared to answer the following questions:

- What is the exact location of the emergency?
  *Flemington Primary School, Mt Alexander Road, Flemington*
  *Melway Ref: Map 29 A11*

- Nearest intersection?
  *The school is located on the corner of Mt Alexander Road and Flemington Street.*
  *Enter the school from Mt Alexander Road via laneway beside large Victorian gates.*

- What is the number of the phone you are calling from?
  *9376 7137*

- What is the problem? / What exactly happened?
- How many people are hurt?
- What is the age of the patient?
- Is the patient conscious?
- Is the patient breathing?

- **DON’T HANG UP**
  Further questions may be required to determine the necessary ambulance response.

2. To assist ambulance:

- Answer each question calmly, accurately.
- Ensure the property is clearly identifiable.
- Have someone wait outside for the ambulance.
- Have any current medication ready.

Ring back on ‘000’ if the patient’s condition changes.
# Minimum Period of Exclusion from Schools and Children's Services Centres for Infectious Diseases Cases and Contacts

The following table indicates the minimum period of exclusion from schools and children’s service centres required for infectious diseases cases and contacts as prescribed under Regulations 13 and 14 of the Health (Infectious Diseases) Regulations 2001 — Schedule 6. In this Schedule 'medical certificate' means a certificate of a registered medical practitioner.

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Exclusion of cases</th>
<th>Exclusion of contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoebiasis (Entamoeba histolytica)</td>
<td>Exclude until diarrhoea has ceased</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Campylobacter</td>
<td>Exclude until diarrhoea has ceased</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>Exclude until fully recovered or for at least 5 days</td>
<td>Any child with an immune deficiency (for example, leukaemia) or receiving chemotherapy should be excluded for their own protection. Otherwise not excluded</td>
</tr>
<tr>
<td>Chicken pox (continued)</td>
<td>after the eruption first appears. Note that some remaining scabs are not a reason for continued exclusion</td>
<td></td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>Exclude until discharge from eyes has ceased</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>Exclude until diarrhoea has ceased or until medical</td>
<td>Not excluded</td>
</tr>
<tr>
<td>certificate of recovery is produced</td>
<td>certificate of recovery is produced</td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Exclude until medical certificate of recovery is</td>
<td>Exclude family / household contacts until cleared to return by the Secretary</td>
</tr>
<tr>
<td>Haemophilus type b (Hib)</td>
<td>received</td>
<td></td>
</tr>
<tr>
<td>Hand, Foot and Mouth disease</td>
<td>Exclude until medical certificate of recovery is received</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Until all blisters have dried</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Herpes ('cold sores')</td>
<td>Exclude until a medical certificate of recovery is</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Human immuno-deficiency virus infection (HIV/AIDS)</td>
<td>received, but not before 7 days after the onset of jaundice or illness</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Impetigo</td>
<td>Exclude until appropriate treatment has commenced.</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Influenza and influenza like Illnesses</td>
<td>Sores on exposed surfaces must be covered with a</td>
<td></td>
</tr>
<tr>
<td>Leprosy</td>
<td>Exclude until approval to return has been given by the</td>
<td>Not excluded</td>
</tr>
<tr>
<td></td>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>Conditions</td>
<td>Exclusion of cases</td>
<td>Exclusion of contacts</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>Measles</td>
<td>Exclude for at least 4 days after onset of rash</td>
<td>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 their first contact with the first case they may return to school</td>
</tr>
<tr>
<td>Meningitis (bacteria)</td>
<td>Exclude until well</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Meningococcal infection</td>
<td>Exclude until adequate carrier eradication therapy has been completed</td>
<td>Not excluded if receiving carrier eradication therapy</td>
</tr>
<tr>
<td>Mumps</td>
<td>Exclude for 9 days or until swelling goes down (whichever is sooner)</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>Exclude for at least 14 days from onset. Re-admit after receiving medical certificate of recovery</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Ringworm, scabies, pediculus (head lice)</td>
<td>Re-admit the day after appropriate treatment has commenced</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Rubella (german measles)</td>
<td>Exclude until fully recovered or for at least four days after the onset of rash</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Salmonella, Shigella</td>
<td>Exclude until diarrhoea ceases</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Severe Acute Respiratory Syndrome (SARS)</td>
<td>Exclude until medical certificate of recovery is produced</td>
<td>Not excluded unless considered necessary by the Secretary</td>
</tr>
<tr>
<td>Streptococcal infection (including scarlet fever)</td>
<td>Exclude until the child has received antibiotic treatment for at least 24 hours and the child feels well</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Trachoma</td>
<td>Re-admit the day after appropriate treatment has commenced</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Exclude until receipt of a medical certificate from the treating physician stating that the child is not considered to be infectious</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Typhoid fever (including paratyphoid fever)</td>
<td>Exclude until approval to return has been given by the Secretary</td>
<td>Not excluded unless considered necessary by the Secretary</td>
</tr>
<tr>
<td>Verotoxin producing Escherichia coli (VTEC)</td>
<td>Exclude if required by the Secretary and only for the period specified by the Secretary</td>
<td>Not excluded</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>Exclude the child for 5 days after starting antibiotic treatment</td>
<td>Exclude unimmunised household contacts aged less than 7 years and close child care contacts for 14 days after the last exposure to infection or until they have taken 5 days of a 10 day course of Antibiotics</td>
</tr>
<tr>
<td>Worms (Intestinal)</td>
<td>Exclude if diarrhoea present</td>
<td>Not excluded</td>
</tr>
</tbody>
</table>

Exclusion of cases and contacts is NOT required for Cytomegalovirus Infection, Glandular fever (mononucleosis), Hepatitis B or C, Hookworm, Cytomegalovirus Infection, Molluscum contagiosum, or, Parvovirus (erythema infectiosum fifth disease).

Published by the Communicable Diseases Section, Victorian Government Department of Human Services — February 2004
HEAD LICE POLICY & PROCEDURE

It is acknowledged that, while parents/guardians have primary responsibility for the detection and treatment of head lice, schools also have a role in the management of head lice infections and in providing support for parents/guardians and students.

Students with head lice have been found in most Victorian schools. Head lice are only passed on through direct hair-to-hair contact with another person who has head lice.

Management Plan

- That head lice inspections by medically trained parents of Flemington Primary School be undertaken at least once a term.

- That parents that undertake the head lice inspections sign a confidentiality agreement before inspections are undertaken.

- A commitment to distribute up-to-date information on the detection, treatment and control of head lice to parents/guardians and staff at the beginning of every year and more frequently if required (available from website http://www.health.vic.gov.au/headlice/).

- A nominated of a head lice resource/support person (parent/guardian or staff member) who parents/guardians can contact at the school at nominated times

- A requirement that parents/guardians refrain from sending their children to school with untreated head lice. (It should be noted that students may be treated one evening and return to school the next day and that the presence of eggs in the hair is not cause for exclusion. Parents/guardians need to be aware that one treatment is not sufficient to manage the problem. If a student re-attends school with live head lice the school may again exclude the student until the live insects have been removed.)

- A commitment to provide parents/guardians with comprehensive advice about the use of safe treatment practices which do not place students’ health at risk

- The proforma Consent Form is to be signed when the student commences school. This will provide permission for the child to be inspected for head lice, and cover the duration of their schooling at the school. This form is available in 21 languages from the Department’s Sofweb website at: www.sofweb.vic.edu.au/wellbeing/headlice/consent_form.htm

- A pro forma letter of notification to parents/guardians of those students found to have head lice, which could incorporate a detachable slip at the bottom, asking parents/guardians to indicate the treatment used and when it commenced (refer to Appendix 5).

- A commitment to help reduce stigma and maintain confidentiality following head lice inspections, e.g. it is recommended that a letter be given to all students involved in inspections, not just those found to have head lice.
Training of appropriate school personnel in detection and management of head lice at the school level.

It is recommended that as well as the head lice inspections undertaken at school at least once a term, it is recommended that parents / guardians could include the following procedures:

- regular (preferably once per week) inspection of their child/children's hair for lice or lice eggs (using conditioner and a head lice comb is the most effective method)
- regular inspection of all household members followed by treatment if head lice are detected
- upon detection of head lice, notify the school and advise when treatment has commenced.
CONSENT FORM TO CONDUCT HEAD LICE INSPECTIONS

Permission to cover the duration of the student’s schooling at:

FLEMINGTON PRIMARY SCHOOL

Throughout your child's schooling, the school will be arranging head lice inspections of students.

The management of head lice infection works best when all children are involved in our screening program.

The school is aware that this can be a sensitive issue and is committed to maintaining student confidentiality and avoiding stigmatisation.

The inspections of students will be conducted by a trained person approved by the principal and school council.

Before any inspections are conducted the person conducting the inspections will explain to all students what is being done and why and it will be emphasised to students that the presence of head lice in their hair does not mean that their hair is less clean or well kept than anyone else’s. It will also be pointed out that head lice can be itchy and annoying and if you know you have got them, you can do something about it.

The person conducting the inspections will check through each student's hair to see if any lice or eggs are present.

Person's authorised by the school principal may also visually check your child's hair for the presence of head lice, when it is suspected that head lice may be present. They do not physically touch the child's head during a visual check.

In cases where head lice are found, the person inspecting the student will inform the student's teacher and the principal. The school will make appropriate contact with the parents/guardians/carers.

Please note that health regulations requires that where a child has head lice, that child should not return to school until appropriate treatment has commenced. The school may request the completion of an 'action taken form', which requires parents/guardians/carers to nominate if and when the treatment has started.

Parent’s/guardian's/carer’s full name: ………………………………………………………………………………………………

Address: ………………………………………………………………………………………… Post code:…………………

Name of child/ren attending the school: ………………………………………………… Yr Level: ………

……………………………………………… Yr Level: ………

……………………………………………… Yr Level: ………

I hereby give my consent for the above named child to participate in the school’s head lice inspection program for the duration of their schooling at this school.

Signature of parent/guardian/carer: …………………………………………… Date: ………………………

Please inform the school if guardianship/custody changes for your child, as this form will need to be re-signed to reflect these changes. Please also inform the school in writing if you no longer wish to provide consent for the school to undertake head lice inspections for your child.
PARENT NOTIFICATION

Child’s Name: ___________________________  Grade: ______________________

Today your child was screened by the volunteer parents of the Flemington Primary School Parent-Managed Head Lice Program, and was found to have the following:

- Live lice
- Old Eggs
- New Eggs
- No evidence of lice or eggs found

Under the Health (Infectious Diseases) Regulations 2001, children found with live lice cannot be readmitted to school until appropriate treatment for lice has commenced.

Please treat your child appropriately by following the attached information sheet on “Management and Treatment of Head Lice”.

Please return the slip below when your child returns to school informing the Principal when treatment has occurred.

If you have any questions or concerns please do not hesitate to contact the school office. Thank you for partaking in this community approach to head lice control.

Lesley McCarthy
Principal

NOTIFICATION OF TREATMENT

Child’s Name: ___________________________  Grade: ______________________

My child was screened on Thursday, 23 November 2006 by the Parent-Managed Head Lice Program and was found to have live lice and/or eggs.

I have treated my child with ___________________________ and they will be returning to school today.

___________________________              ______________________
Parents Names (Please Print)                  Parent Signature              __/__/200

Date
Flemington Primary School

SunSmart Policy

2004 Review
Ratified by school council 2004

1. **Rationale:**
   Our Sunsmart policy has been developed to ensure that all children attending this school are protected from excessive heat and skin damage caused by the harmful ultra-violet rays of the sun. Children are encouraged to be SunSmart throughout the entire year, however particular SunSmart regulations apply during Terms One and Four – the terms when UV radiation is strongest.

**Aims:**
3. The policy aims to educate students as to suitable Sunsmart protection strategies and to encourage children, parents and teachers to protect themselves from the harmful effects of the sun while at school. As part of general SunSmart strategies, our school will:

**Implementation**

**Behaviour**
- Require all children to wear hats which protect the face, neck and ears whenever they are outside (e.g. recess, lunch, sport, excursions) during Terms One and Four. Students are strongly encouraged to wear hats during terms 2 & 3.
- Require all children to wear appropriate clothing at all times, eg tops/dresses that cover their stomachs and shoulders.
- Encourage the parent community to provide SPF 30+ broad spectrum, water resistant sunscreen for student use whenever possible.
- Encourage children to use available areas of shade for outdoor activities.
- Expect children who do not have the appropriate Sunsmart clothing to remain in the shades areas during all outdoor activities and play times.
- Encourage the parent community to support the wearing of hats to and from school during Terms 1 and 4.
- Expect/ request staff and encourage parents to act as role models by practising SunSmart behaviours.
- Expect/request staff to model SunSmart behaviour when participating in outdoor activities and yard duty.
Curriculum

- Incorporate programs on skin cancer prevention and SunSmart behaviours into the curriculum at all grade levels.
- Publish reminders in the school newsletter.
- Regularly reinforce SunSmart behaviour in a positive way through newsletters, parent meetings, student and teacher activities.
- Ensure the SunSmart policy is reflected in the planning of outdoor events where possible (eg. Camps, excursions, sporting events).

Environment

- Provide sun protective clothing as part of our school uniform.
- Schedule outdoor activities before 11am and after 3pm (10am and 2pm during daylight saving times) during Terms 1 and 4 whenever possible.
- Require children to be inside on days on which it is deemed (by staff/leadership) it to be too hot to be involved in outside activities.
- Schedule outdoor assemblies early in the day or in areas where students can be in the shade.
- Organize outdoor activities to be held in areas of shade whenever possible.

Evaluation:

Future Goals & priorities

1. The Welfare Team will review the effectiveness of this policy each 3 years.

2. Assess shade provision and usage and make recommendations for increases in shade provision.

3. Provide more communication to parents regarding the requirements of our SunSmart policy and encouraging SunSmart behaviour.
CONSENT FOR MEDICATION

NAME OF CHILD:  

GRADE:  

Please provide details of medication, dosage, times, etc.

Medication:  

Dosage:  

Times:  

Comments:  

Please note that ALL medicines are to be clearly labelled with your child’s name and required dosage of medication.

I consent to school staff supervising the administering of the above medicines to my child.

Signed:  

Date:  

Office Use Only

Medication Administered

<table>
<thead>
<tr>
<th>Date</th>
<th>Time Administered</th>
<th>Administered by (name)</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
SCHOOL CAMP ASTHMA ACTION PLAN

FORM 1

This record is to be completed by parents/caregivers in consultation with their child’s doctor (general practitioner). Please tick (√) the appropriate box and print your answers clearly in the blank spaces where indicated. This school is collecting information on your child’s asthma so we can better manage asthma while your child is in our care. The information on this Plan is confidential. All staff that care for your child will have access to this information to provide safe asthma management for your child at school and on camp. The school will only disclose this information to others with your consent. Please contact the school at any time if you need to update this plan or you have any questions about the management of asthma at school. If no Asthma Action Plan is provided by the parent/carer, the staff will treat asthma symptoms as outlined in the Victorian Schools Asthma Policy: 2003.

Student’s Name ________________________________ Gender M ☐ F ☐
Age ______________ / / __ Form/Class ______________
Name of Emergency Contact (eg. parent / carer) _____________________________
Phone (H) ___________ (B/H) ___________ Mobile _____________________________
Doctor’s Name ___________________________ Phone _____________________________
Ambulance Subcriber Y ☐ N ☐ Subscriber no. __________________ Medicare No. __________________

PHOTO (optional)

USUAL ASTHMA ACTION PLAN

Usual signs of student’s asthma
Wheezing ___________ ☐
Tightness in chest ___________ ☐
Coughing ___________ ☐
Difficulty in breathing ___________ ☐
Difficulty speaking ___________ ☐
Other (please describe) __________________

Worsening signs of student’s asthma
Increased signs of:
Wheezing ___________ ☐
Tightness in the chest ___________ ☐
Coughing ___________ ☐
Difficulty in breathing ___________ ☐
Difficulty speaking ___________ ☐
Other (please describe) __________________

What trigger’s the student’s asthma
Exercise ___________ ☐
Colds/viruses ___________ ☐
Pollens ___________ ☐
Dust ___________ ☐
Smoke ___________ ☐
Weather changes ___________ ☐
Other triggers (please describe) __________________

Does your child need assistance taking their medication? Y ☐ N ☐

Any other information that will assist with the asthma management of the student while on camp eg. peak expiratory flow action plan, night time asthma, recent attacks

_____________________________________________________

Medication requirements: (including medication before exercise)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Method (e.g. puffer &amp; spacer, Turbuhaler, Accuhaler)</th>
<th>When, and how much</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

2006
FPS First Aid Policy & Procedures

SCHOOL CAMP ASTHMA ACTION PLAN
FORM 1

Asthma First Aid Plan

Please tick (✓) preferred First Aid Plan:

☐ Victorian Schools Asthma Policy for Asthma First Aid

Section 4.5.7.8 of the Department of Education and Training’s Victorian Schools Reference Guide
1. Sit the student down and remain calm to reassure the student. Do not leave the student alone.
2. Without delay shake a blue reliever puffer (Ventolin, Aironir, Asmol or Epaq) and give 4 separate puffs, through a spacer (spacer technique - 1 puff/take 4 breaths from spacer, repeat until 4 puffs have been given).
3. Wait 4 minutes. If there is no improvement, give another 4 separate puffs, as per step 2.
4. Wait 4 minutes. If there is no improvement, call an ambulance (dial 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.

If at any time the student’s condition worsens, call an ambulance immediately.

OR

☐ Student’s Asthma First Aid Plan (if different from above)

- Please notify me if my child regularly has asthma symptoms at school/camp.
- Please notify me if my child has received asthma first aid.
- In the event of an asthma attack at camp, I agree to my son/daughter receiving the treatment described above.
- I authorise school staff to assist my child with taking asthma medication should they require help.
- I will notify you in writing if there are any changes to these instructions.
- I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent’s / Guardian’s Signature: ___________________________ Date _____ / ____ / _____

Doctor’s Signature: ___________________________ Date _____ / ____ / _____

Doctor’s Provider Number ————————————————————

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly™ Schools Program and asthma management please contact: The Asthma Foundation of Victoria on (03) 9326 7086 or Toll Free 1800 645 130 or visit our website

2005
SCHOOL CAMP ASTHMA ACTION PLAN
FORM 2
MEDICAL UPDATE FORM

Complete this form and return it to school the day BEFORE your child leaves for camp. Form 1 (School Camp Action Plan) and this Form 2 should both be taken to camp. This form will ensure that staff have the most up-to-date medical information about the student and their asthma.

Student’s Name__________________________________________________________

Parent’s / Guardian’s Names________________________________________________

Address________________________________________________________________

Phone Home ( ) Work ( ) Mobile

Emergency Contact Name_________________________________________ Phone ( ) Mobile

Ambulance Subscriber Y □ N □ Subscriber no.___________________________ Medicare No.__________________________

1. Has the student been hospitalised or had an asthma attack or had worsening asthma in the last two (2) weeks before camp? ___________________________ Y □ N □

2. Is the student well enough to attend camp? ____________________________ Y □ N □

3. Has the student’s medications changed in the last two (2) weeks? ____________________________ Y □ N □

   If yes please provide details of new medication requirements

   Medication requirements: (including medication before exercise)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Method (e.g. puffer &amp; spacer, turbuhaler)</th>
<th>When, and how much</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

4. Has the student had any other illness in the last two (2) weeks? ____________________________ Y □ N □

   If yes, please give details of illness Nature of illness? ____________________________

   When? ____________________________ Severity? ____________________________

Parent’s / Guardian’s Signature: __________________________________________ Date ______/____/____

2005
# SCHOOL ASTHMA ACTION PLAN

This record is to be completed by parents/caregivers in consultation with their child’s doctor (general practitioner). Please tick (✓) the appropriate box and print your answers clearly in the blank spaces where indicated.

This school is collecting information on your child’s asthma so we can better manage asthma while your child is in our care. The information on this Plan is confidential. All staff that care for your child will have access to this information. It will only be distributed to them to provide safe asthma management for your child at school. The school will only disclose this information to others with your consent if it is to be used elsewhere. Please contact the school at any time if you need to update this Plan or you have any questions about the management of asthma at school. If no Asthma Action Plan is provided by the parent/carer, the staff will treat asthma symptoms as outlined in the Victorian Schools Asthma Policy, 2003.

**Student’s Name** 

**Gender** Male [✓] Female [ ] **Age** 

**Date of Birth** / / **Form/Class**

**Emergency Contact** (e.g. Parent/Carer) 

**Relationship** 

**Phone** (H) ________ (B/H) ________ **Mobile** ________ 

**Doctor’s Name** 

**Phone** ________

**Ambulance Subscriber** [✓] No [ ] **Subscriber no.** ________

**Medicare No.** ________

---

## USUAL ASTHMA ACTION PLAN

### Usual signs of child’s asthma

- Wheezing [ ]
- Tightness in chest [ ]
- Coughing [ ]
- Difficulty in breathing [ ]
- Difficulty speaking [ ]
- Other (please describe) [ ]

### Worsening signs of child’s asthma

- Increased signs of: 
  - Wheezing [ ]
  - Tightness in chest [ ]
  - Coughing [ ]
  - Difficulty in breathing [ ]
  - Difficulty speaking [ ]
  - Other (please describe) [ ]

### What triggers the child’s asthma?

- Exercise [ ]
- Colds/Viruses [ ]
- Pollens [ ]
- Dust [ ]
- Other Triggers (please describe) [ ]

Does your child need assistance taking their medication? [✓] No [ ]

---

Asthma medication requirements usually taken at school:

(including preventers, symptom controllers, combination medication, medication before exercise)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Method (e.g. puffer &amp; spacer, turbohaler)</th>
<th>When, and how much?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is your child on regular preventer medication taken at home? [✓] No [ ]

----

2006
Asthma First Aid Plan

Please tick (✓) preferred First Aid Plan:

☐ Victorian Schools Asthma Policy for Asthma First Aid

   (Section 4.5.7.8 of Department of Education and Training's Victorian Government Schools' Reference Guide.

   1. Sit the student down and remain calm to reassure the student. Do not leave the student alone.

   2. Without delay shake a blue reliever puffer (names include Ventolin, Aromir, Asmol or Epaq) and give 4 separate puffs, through a spacer (spacer technique - 1 puff / take 4 breaths from spacer, repeat until 4 puffs have been given).

   3. Wait 4 minutes. If there is no improvement, give another 4 separate puffs, as per step 2.

   4. Wait 4 minutes. If there is no improvement, call an ambulance (dial 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.

   If at any time the student's condition suddenly worsens, call an ambulance immediately.

   OR

☐ Student’s Asthma First Aid Plan (if different from above)

   • Please notify me if my child regularly has asthma symptoms at school.
   • Please notify me if my child has received asthma first aid.
   • In the event of an asthma attack at school, I agree to my son/daughter receiving the treatment described above.
   • I authorise school staff to assist my child with taking asthma medication should they require help.
   • I will notify you in writing if there are any changes to these instructions.
   • I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent’s / Guardian’s Signature: ______________________________ Date __/__/____

Doctor’s Signature: ______________________________ Date __/__/____

Doctor’s Provider Number: ______________________________

For further information about the Victorian Schools Asthma Policy, the Asthma Friendly™ Schools Program and asthma management please contact: The Asthma Foundation of Victoria on (03) 9326 7088 or Toll Free 1800 645 130 or visit our web site www.asthma.org.au

2005