



ASTHMA ACTION PLAN

Primary Campus
28 Vo Truong Toan St.,
An Phu, Dist. 2, HCMC

Secondary Campus
1 Xuan Thuy St., Thao Dien,
Dist. 2, HCMC

Tel: (84-28) 3898 9100
Fax: (84-28) 3898 9382
Email: admissions@ishcmc.edu.vn

www.ishcmc.com

Student's Name: **Date:**/...../.....

Class: **Visa/FIN number:**

Your child's signs and symptoms of Asthma?
(please select all applicable symptoms)

Wheeze	Tight Chest	Cough	Difficulty Breathing
Shortness of breath			

What triggers have been identified
(please select all applicable)

Exercise	Smoke	Haze	Dust
Cold/Flu	Pollens		

When Well

Preventer (if prescribed)	How much	How often
		Times/day
		Times/day
Reliever: Ventolin (salbutamol)		

Usual Peak Expiratory Flow Rate (if known):

When Not Well

	How much	How often
Ventolin (salbutamol) (delivered via a spacer)	1puff : 4 breaths 1puff : 4 breaths 1puff : 4 breaths 1puff : 4 breaths	Repeat after 4 minutes
Preventer:		Times/day
		Times/day
		Times/day

- Avoid strenuous activities and physical exercise.
- If the child is not improving after 2 cycles of Ventolin treatment contact parents/guardian



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Consent

- In the event of an asthma episode, I consent to my son/daughter receiving the treatment described above.
- I authorise school staff to assist my child with taking asthma medication.
- I will notify the School in writing/email if there are any changes to medication or management.
- I undertake to provide to the School a "Request to Administer Medication Form" to administer Ventolin at the beginning of each year.
- I will indemnify and hold the School harmless against any loss or liability incurred as a result of providing the medical assistance to my child as set out in this form.

Parents Signature.....Name.....Date:/...../.....