LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la Santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

PAI - Individualised Support Plan
ASTHMA

⚠ This interactive page requires Adobe Acrobat® Reader® version 8.1.3 or higher. The latest version of Adobe Acrobat Reader for all systems (Windows, Mac, etc.) can be downloaded for free on the Adobe Systems Incorporated website.

Your rights regarding your personal data:

The information about you collected from this form needs to be processed by the public administration concerned.
That information is kept by the administration in question for as long as it is required to achieve the purpose of the processing operation(s).
Your data will be shared with other public administrations that are necessary for the processing of your application. For details on which departments will have access to the data on this form, please contact the public administration you are filing your application with.
Under the terms of Regulation (EU) 2016/679 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, you have the right to access, rectify or, where applicable, remove any information relating to you. You are also entitled to withdraw your consent at any time. Additionally, unless the processing of your personal data is compulsory, you may, with legitimate reasons, oppose the processing of such data.
*If you wish to exercise these rights and/or obtain a record of the information held about you, please contact the **Ministry of Health**. If the contact details of the competent service are not indicated, you can contact the Data Protection Officer at the **Ministry of Health** by email at info_donnees@ms.etat.lu. You are also entitled to file a claim with the National Commission for Data Protection (Commission nationale pour la protection des données), headquartered at 1, Avenue du Rock'n'Roll, L-4361 Esch-sur-Alzette*

1. Input

Fields marked with an * are mandatory

Identity of the applicant

Photo

ONLY for School Medical Service:

Child's/Student's family name(s):*

Child's/Student's first name(s):*

Nat. identification number(matricule):*
(or date of birth if no id number)

Cycle / class:

School/SEA:*

Place/Location:*

Name(s) of legal representative/parents:*

Address:*

Telephone:

Email address:

MSA_DSA_PAI-AS_E_202002_0

LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la Santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

Delegation of care

Fields marked with an * are mandatory

I,* _____

the undersigned, legal representative or adult student, request for my child or myself the implementing of an Individualised Support Plan (PAI) based on the medical prescription and emergency intervention protocol established by

Dr* _____

I authorise that this document be made known and applied by the people in charge of the student/child or myself : school, school health team, day care centre/SEA, SePAS.
It is my responsibility:

- to check the expiry date of medicines
- to replace them as soon as they reach the expiry date
- in the event of a change in the medical prescription, to inform the people responsible for the child/student and the school health team

Signature (mandatory)

Place:* _____

Date:* _____

Signature of legal representative or adult student:* _____

Prescribing physician

Name:* _____

Date:* _____

Signature:* _____

For the doctor at the National Health Directorate - Department for School Medicine and Health of Children and Young People

PAI received on: _____

forwarded to: _____

on: _____

Signature: _____

MSA_DSA_PAI-AS_E_202002_0

Child's/Student's family name(s): _____ Nat. identification number: _____

LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la Santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

2. Supervisory staff

School health team	Name	Job title	Tel. no.
Headteachers	Name	Job title	Tel. no.
Supervisory staff at day-care centre	Name	Job title	Tel. no.
SePAS/ESEB	Name	Job title	Tel. no.
Others	Name	Job title	Tel. no.

3. Doctors treating the child

Family doctor (GP)	Name	Address	Tel. no.
Specialists	Name	Address	Tel. no.

Child's/Student's family name(s): _____ Nat. identification number: _____

LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la Santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

4. Transmission of the PAI / Concertation meeting

Information session:

Date:

Attendance list - People who have knowledge of the PAI

(give names and job titles of all people who have knowledge of the PAI)

Job title	Family name/First name	Signature	Date
Head teacher			
Educator			
Person in charge of the day-care centre			
Staff at day-care centre			
SEPAS			
ESEB			
Others			
Others			
Others			

For the School Health Team

A copy of the PAI has been handed to:

Date:

IMPORTANT: Instructions for staff responsible for the child/student:

- **Please inform the school principals in basic/secondary education establishments, the teachers, the supervisory staff and the supply teachers of the existence of this document.**
- **Send a copy of this page to *Division de la Médecine scolaire* (by post to: 20 Rue de Bitbourg, L-1273 Luxembourg-Hamm, or by email to pai@ms.etat.lu) after the people concerned have read the PAI and their signatures have been obtained.**

Child's/Student's family name(s): Nat. identification number:

LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la Santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

5. EMERGENCY ACTION PLAN - ASTHMA

IN THE EVENT OF AN ASTHMA ATTACK:

Symptoms:

- dry cough and/or
- constant coughing and/or
- difficulty breathing and/or
- wheezing/whistling and/or
- nasal flaring and/or
- change in skin colour (pale, blue, etc) and/or
- difficulty speaking

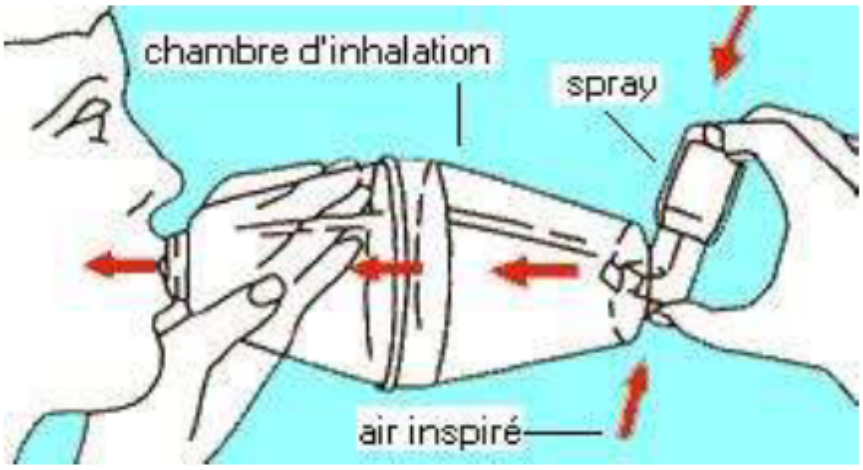
■ **What you should do => TAKE ACTION IMMEDIATELY**

1. Administer the following medicines:

BREATHING ASSISTANCE

short acting bronchodilatators administered using a spacer device:

VENTOLIN -100 inhaler: ..... puffs, repeated every ..... **minutes**



2. If the signs become worse, or continue: **CALL THE SAMU EMERGENCY (112)**

3. Inform the **parents**

Signature

Place:* _____

Date:* _____

Stamp of the doctor:* _____

Child's/Student's family name(s): _____ Nat. identification number: _____

LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la Santé

- ◯ Initial PAI
- ◯ Updated PAI
- ◯ Indefinite duration
- ◯ Valid for ____ / ____

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

6. Instructions

1. Emergency kit

PLACE A COPY OF THIS DOCUMENT IN THE EMERGENCY KIT

Content / Medicines	Expiry date
Location	
School ☐	
Day-care centre/SEA ☐	
Other ☐	

- **IF THE SAMU EMERGENCY SERVICE IS CALLED, INFORM THEM OF THE EXISTENCE OF THIS DOCUMENT**
- **INFORM THE PARENTS**
- **THE EMERGENCY KIT MUST FOLLOW THE CHILD ON ALL JOURNEYS OUTSIDE THE SCHOOL**

2. Conditions for support

Physical activities	Excursions	Others
☐ not allowed	☐ not allowed	☐ no restrictions
☐	☐	☐ other (give details):
☐	☐	☐
☐	☐	☐
☐	☐	☐

3. Any other arrangements:

Signature

Place:*

Date:*

Stamp of the doctor:*

Child's/Student's family name(s): Nat. identification number: