

Asthma care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Description of the condition

Signs and symptoms:

- Difficulty breathing
- Wheeze
- Tightness of chest
- Cough

Frequency and severity:

- Frequently (more than 5 x per year)
- Occasionally (less than 5 x per year)
- Daily/most days
- Other (please specify) _____

Triggers (eg exercise, chalk dust, animals, food pollens, chemicals, weather, grasses, lawn mowing) _____

Is this student able to self manage their asthma? YES NO

- Remember to bring their puffer to school (clearly labelled with the original pharmacist label)
- Keep their puffer handy at all times
- Take responsibility for using their medication as directed by their doctor, e.g. before exercise
- Tell staff if they are having an asthma attack, even if they can manage it themselves. Staff need to know about the asthma attack in case it gets worse.

Curriculum considerations (eg physical activity, camps, excursions, kitchen, laboratory or workshop activities, interrupted attendance)

Additional information attached to this care plan

- Medication plan
- Individual first aid plan (if different to standard first aid—see model over page)
- General Information about this person's condition
- Other (please specify) _____

This plan has been developed for the following services/settings: *

- | | |
|--|--|
| <input type="checkbox"/> School/education | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care | <input type="checkbox"/> Work |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (please specify): _____ |

AUTHORISATION AND RELEASE

Health professional: _____ Professional role: _____

Address: _____

Telephone: _____

Signature _____ Date: _____

I have read, understood and agreed with this plan and any attachments indicated above.

I approve the release of this information to supervising staff and emergency medical personnel.

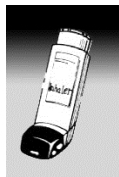
Parent/guardian

or adult student/client _____ Signature _____ Date _____

Family name (please print) First name (please print)

Asthma first aid plan

- **SIT** person up
- **REASSURE**
- **STAY** with person



Give blue/grey reliever puffer

- 4 puffs via spacer
- 4 breaths after each puff

ASTHMA RELIEVED

ASTHMA PERSISTS
after 4 minutes

SEVERE BREATHING PROBLEMS
Person looks blue

NO RELIEF

 **CALL AMBULANCE**

 **REPEAT RELIEVER**

- 4 puffs via spacer every 4 minutes

STOP TREATMENT

Observe

RELIEF

STOP TREATMENT

Cease physical activity



TO CALL AMBULANCE: Dial out, then 000 or mobile 112
Say what state you are calling from, the person's condition and location



INFORM EMERGENCY CONTACTS in accordance with DECD guidelines