

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: Frequency and severity:

- | | |
|---|--|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Frequently (more than 5 x per year) |
| <input type="checkbox"/> Wheeze | <input type="checkbox"/> Occasionally (less than 5 x per year) |
| <input type="checkbox"/> Tightness of chest | <input type="checkbox"/> Daily/most days |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Other (please specify) _____ |

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

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

Authorised prescriber _____ 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

REPEAT RELIEVER



- 4 puffs via spacer
- 4 breaths after each puff

NO RELIEF

RELIEF

CALL AMBULANCE



STOP TREATMENT

STOP TREATMENT

REPEAT RELIEVER

Observe

Cease physical activity

Resume activity

Observe

- 4 puffs via spacer every 4 minutes



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 DECS guidelines