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.

Double click in the grey fields below to enter text or tick a box
Document will expand to accommodate text

Name of child/student/client: _____ Date of birth: _____
Family name, First name

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: *

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ 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: _____
Family name, First name

Signature: _____ Date: _____

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

STOP TREATMENT

Observe

ASTHMA PERSISTS after 4 minutes

REPEAT RELIEVER

- 4 puffs via spacer
- 4 breaths after each puff

RELIEF

STOP TREATMENT

Cease physical activity

SEVERE BREATHING PROBLEMS
Person looks blue

NO RELIEF

CALL AMBULANCE

REPEAT RELIEVER

- 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 DECD guidelines

Department for Education and Child Development with expert advice from Australian Red Cross SA Division and Asthma SA