## Asthma care plan

for education, child/care and community support services\*

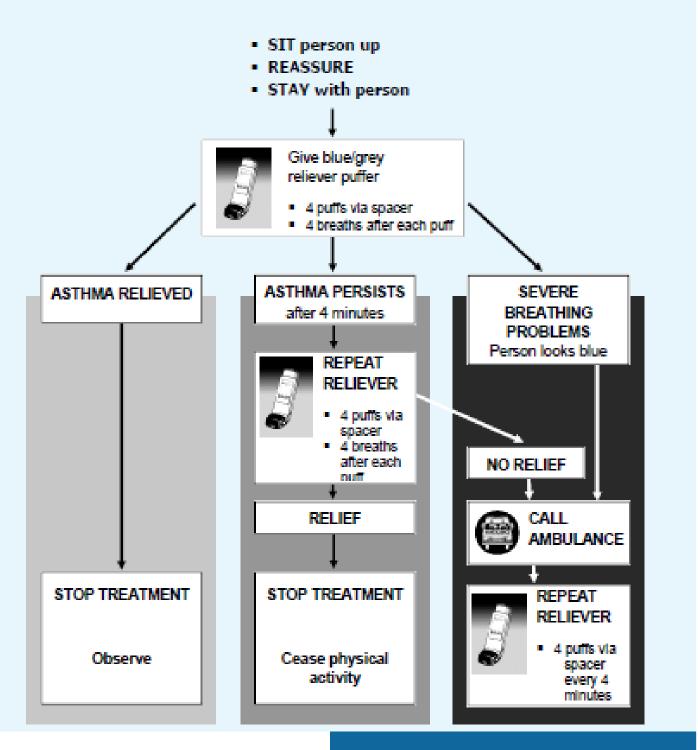
## **CONFIDENTIAL**

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:
MedicAlert Number (if relevant):	Date for next review:
Description of the condition	
Signs and symptoms: F	requency and severity:
☐ Difficulty breathing	☐ Frequently (more than 5 x per year)
☐ Wheeze	Occasionally (less than 5 x per year)
☐ Tightness of chest	☐ Daily/most days
Cough	Other: (please specify)
Triggers: (eg exercise, chalk dust, animals, l	food pollens, chemicals, weather, grasses, lawn mowing)
Is this student able to self ma	anage their asthma? YES □ NO□
	nool (clearly labelled with the original pharmacist label)
Keep their puffer handy at all times  Take responsibility for using their meaning their many the many their many their many their many their many their many the	disation as directed by their dector, a substance eversion
	dication as directed by their doctor, e.g. before exercise attack, even if they can manage it themselves. Staff need to know about the asthma
attack in case it gets worse.	rations, even in they can manage it diemselves. Stain need to know about the astimu
Curriculum considerations: (e	g physical activity, camps, excursions, kitchen, laboratory or workshop activities, interrupted
attendance)	
Additional information attach	ed to this care plan
Medication plan	led to this care plan
<u> </u>	o standard first aid—see model over page)
General Information about this person	
Other: (please specify)	
This plan has been developed for the	e following services/settings: *
☐ School/education	Outings/camps/holidays/aquatics
Child/care	☐ Work
Respite/accommodation	Home
☐ Transport	Other: (please specify)
AUTHORISATION AND RELEASE	
Health Professional:	Professional role:
Address:	
Telephone:	
Signature:	Date:
,	ith this plan and any attachments indicated above.
I approve the release of this information	on to supervising staff and emergency medical personnel.
Parent/guardian or adult student/client:	Family name, First name
Signature:	Date:

## Asthma first aid plan





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 Australian