

# Asthma care plan for education and care services



Photo of child (optional)

**CONFIDENTIAL:** Staff are trained in asthma first aid (see overleaf) and can provide routine asthma medication as authorised in this care plan by the treating doctor. Please advise staff in writing of any changes to this plan.

To be completed by the treating doctor and parent/guardian, for supervising staff and emergency medical personnel.

## PLEASE PRINT CLEARLY

Plan date  
\_\_\_/\_\_\_/201\_\_\_

Review date  
\_\_\_/\_\_\_/201\_\_\_

Child's name

Date of birth

## Managing an asthma attack

Staff are trained in asthma first aid (see overleaf). Please write down anything different this child might need if they have an asthma attack:

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## Daily asthma management

*This child's usual asthma signs*

- Cough
- Wheeze
- Difficulty breathing
- Other (please describe)

*Frequency and severity*

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

*Known triggers for this child's asthma (eg exercise\*, colds/flu, smoke) — please detail:*

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Does this child usually tell an adult if s/he is having trouble breathing?  Yes  No

Does this child need help to take asthma medication?  Yes  No

Does this child use a mask with a spacer?  Yes  No

\*Does this child need a blue reliever puffer medication before exercise?  Yes  No

## Medication plan

If this child needs asthma medication, please detail below and make sure the medication and spacer/mask are supplied to staff.

Name of medication and colour	Dose/number of puffs	Time required

**Doctor**

Name of doctor

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Address

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Phone

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Signature

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Date

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**Parent/Guardian**

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.

Signature

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Date

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Name

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**Emergency contact information**

Contact name

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Phone

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Mobile

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Email

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# Asthma First Aid

## 1 Sit the person upright

- Be calm and reassuring
- Do not leave them alone



## 2 Give 4 separate puffs of blue/grey reliever puffer

- Shake puffer
- Put 1 puff into spacer
- Take 4 breaths from spacer

Repeat until 4 puffs have been taken

Remember: Shake, 1 puff, 4 breaths

OR give 2 separate doses of a Bricanyl inhaler (age 6 & over) or a Symbicort inhaler (over 12)



## 3 Wait 4 minutes

- If there is no improvement, give 4 more separate puffs of blue/grey reliever as above

OR give 1 more dose of Bricanyl or Symbicort inhaler



## 4 If there is still no improvement call emergency assistance - Dial Triple Zero (000)

- Say 'ambulance' and that someone is having an asthma attack
- Keep giving 4 separate puffs every 4 minutes until emergency assistance arrives

OR give 1 dose of a Bricanyl or Symbicort every 4 minutes - up to 3 more doses of Symbicort



### Call emergency assistance immediately - Dial Triple Zero (000)

- If the person is not breathing
- If the person's asthma suddenly becomes worse or is not improving
- If the person is having an asthma attack and a reliever is not available
- If you are not sure if it's asthma
- If the person is known to have Anaphylaxis - follow their Anaphylaxis Action Plan, then give Asthma First Aid

Blue/grey reliever medication is unlikely to harm, even if the person does not have asthma



Contact your local Asthma Foundation

**1800 ASTHMA Helpline** (1800 278 462) [asthmaaustralia.org.au](http://asthmaaustralia.org.au)

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