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:
☐ *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, 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	☐ 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: _____

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)

A first aid guide for education and children's services

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

Resume activity

ASTHMA PERSISTS after 4 minutes

REPEAT RELIEVER
- 4 puffs via spacer
- 4 breaths after each puff

RELIEF

STOP TREATMENT

Cease physical activity

Observe

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 DECS guidelines

Department of Education and Children's Services SA with expert advice from Australian Red Cross SA Division and St John Ambulance Australia SA Inc, 2007 and Asthma SA