

# 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: \_\_\_\_\_

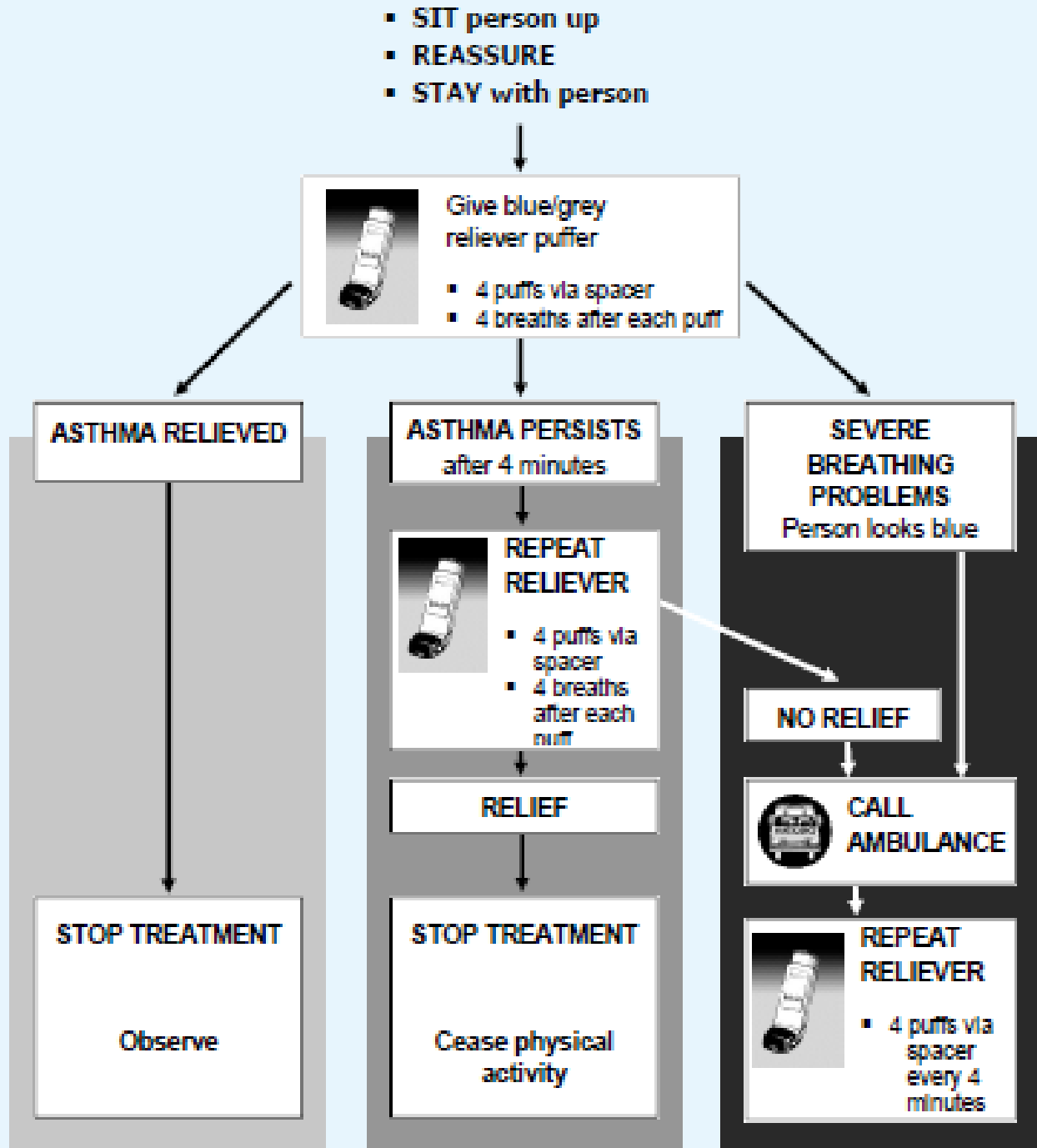
**I have read, understood and agreed with this plan and any attachments indicated above.**

**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



**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