

# 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:

- 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) \_\_\_\_\_

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: \*

- |  |  |
|--|--|
| <input type="checkbox"/> School/education      | <input type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care            | <input type="checkbox"/> Work                            |
| <input type="checkbox"/> Respite/accommodation | <input type="checkbox"/> Home                            |
| <input type="checkbox"/> Transport             | <input type="checkbox"/> Other (please specify) _____    |

#### AUTHORISATION AND RELEASE

Authorised prescriber \_\_\_\_\_ Professional role \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

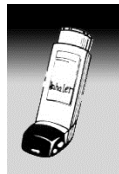
Signature \_\_\_\_\_ Date \_\_\_\_\_

**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)

# 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**

**ASTHMA PERSISTS**  
after 4 minutes

**SEVERE BREATHING PROBLEMS**  
Person looks blue



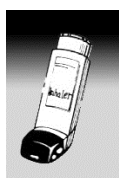
**REPEAT RELIEVER**

- 4 puffs via spacer
- 4 breaths after each puff

**NO RELIEF**



**CALL AMBULANCE**



**REPEAT RELIEVER**

- 4 puffs via spacer every 4 minutes

**STOP TREATMENT**

**Observe**

**Resume activity**

**RELIEF**

**STOP TREATMENT**

**Cease physical activity**

**Observe**



**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