

Asthma care plan

for schools, preschools and childcare services

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN/ADULT STUDENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student.....Date of birth
Family name (please print) First name (please print)

Medic Alert number (if relevant).....Review date

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)

First aid

If a child/student has an asthma attack at school/preschool/child care, staff will administer basic asthma first aid:

Assess Is it mild, moderate or severe?

Sit Upright, stay calm and reassure

Treat 4 separate puffs of blue/grey reliever medication with a spacer if available.
Repeat in 4 minutes if no improvement.

Help Call for an ambulance if no improvement or when in doubt.

Monitor Observe person. Repeat medication every 4 minutes as required.

All OK Resume activity if free of symptoms. STOP activity if treatment was repeated or symptoms persist.

If you anticipate this child/student will require something other than this standard first aid response, please provide detailed written recommendations so special arrangements can be negotiated.

Additional information attached to this care plan

- Medication plan (if supervision of medication is recommended at school/preschool or childcare)
- Individual first aid plan (if different to standard first aid-see model over page)
- General information about this child's/student's condition
- Other (please specify)

AUTHORISATION AND RELEASE

Medical practitioner 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 education/childcare staff and emergency medical personnel.

Parent/guardian
or adult student Signature Date
Family name (please print) First name (please print)