ASTHMA CARE PLAN FOR EDUCATION AND CARE SERVICES

PHOTO OF STUDENT (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
____/____/20____

Review date
____/____/20____

Student's name: _____ **DOB:** _____

MANAGING AN ASTHMA ATTACK

Staff are trained in Asthma First Aid (see overleaf). Please write down anything different this student might need if they have an asthma attack:

_____

_____

DAILY ASTHMA MANAGEMENT

This student'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 student's asthma (e.g. exercise*, colds/flu, smoke) — please detail:

_____

_____

_____

_____

_____

_____

Does this student usually tell an adult if s/he is having trouble breathing?	☐ **Yes**	☐ **No**
Does this student need help to take asthma medication?	☐ **Yes**	☐ **No**
Does this student use a mask with a spacer?	☐ **Yes**	☐ **No**
*Does this student need a blue/grey reliever puffer medication before exercise?	☐ **Yes**	☐ **No**

MEDICATION PLAN

If this student 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

Address

Phone

Signature **Date**

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 **Date**

Name

EMERGENCY CONTACT INFORMATION

Contact name

Phone

Mobile

Email

For asthma information and support, or to speak with an Asthma Educator, call **1800 ASTHMA** (1800 278 462) or visit **asthma.org.au**

ASTHMA AUSTRALIA

ASTHMA FIRST AID

Blue/Grey Reliever

Airomir, Asmol, Ventolin or Zempreon and Bricanyl

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

DIAL TRIPLE ZERO (000) FOR AN AMBULANCE IMMEDIATELY IF THE PERSON:

- is not breathing
- suddenly becomes worse or is not improving
- is having an asthma attack and a reliever is not available
- is unsure if it is asthma
- **has a known allergy to food, insects or medication and has SUDDEN BREATHING DIFFICULTY, GIVE ADRENALINE AUTOINJECTOR FIRST (if available), even if there are no skin changes, then use a reliever**

1 

SIT THE PERSON UPRIGHT

- Be calm and reassuring
- Do not leave them alone

2 

GIVE 4 SEPARATE PUFFS OF RELIEVER PUFFER

- Shake puffer
- Put 1 puff into spacer
- Take 4 breaths from spacer
  - **Repeat** until 4 puffs have been taken

If using **Bricanyl,** give 2 separate inhalations (5 years or older)

If you don't have a spacer handy in an emergency, take 1 puff as you take 1 slow, deep breath and hold breath for as long as comfortable. **Repeat** until all puffs are given

3 

WAIT 4 MINUTES

- If breathing does not return to normal, give 4 more separate puffs of reliever as above

Bricanyl: Give 1 more inhalation

IF BREATHING DOES NOT RETURN TO NORMAL

4 

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

Bricanyl: Give 1 more inhalation every 4 minutes until emergency assistance arrives

ASTHMA AUSTRALIA

1800 ASTHMA
(1800 278 462)
asthma.org.au

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