

ASTHMA CARE PLAN FOR EDUCATION AND CARE SERVICES

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.

PHOTO OF STUDENT
(OPTIONAL)

To be completed by the treating doctor and parent/guardian, for supervising staff and emergency medical personnel.

PLEASE PRINT CLEARLY

Student's name: _____ DOB: _____

Plan date
___/___/20__

Review date
___/___/20__

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 _____





ASTHMA FIRST AID

1



SIT THE PERSON UPRIGHT

- Be **calm** and reassuring
- **Do not leave** them alone

2



GIVE 4 SEPARATE PUFFS OF BLUE/GREY RELIEVER PUFFER

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

OR give 2 separate doses of a Bricanyl inhaler (age 6 & over) or a Symbicort inhaler (over 12)

3



WAIT 4 MINUTES

- If there is no improvement, **give 4 more separate puffs of blue/grey reliever** as above

OR give 1 more dose of Bricanyl or Symbicort inhaler

IF THERE IS STILL NO IMPROVEMENT

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

OR give 1 dose of a Bricanyl or Symbicort every 4 minutes – up to 3 more doses of Symbicort



Translating and
Interpreting Service
131 450



**ASTHMA
AUSTRALIA**

Contact Asthma Australia

1800 ASTHMA
(1800 278 462)

asthma.org.au

CALL EMERGENCY ASSISTANCE IMMEDIATELY AND DIAL TRIPLE ZERO (000) IF:

- the person is not breathing
- the person's asthma suddenly becomes worse or is not improving
- the person is having an asthma attack and a reliever is not available
- you are not sure if it's asthma
- the person is known to have Anaphylaxis – follow their Anaphylaxis Action Plan, then give Asthma First Aid

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