

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.

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

PLEASE PRINT CLEARLY

Student's name: _____ DOB: _____

PHOTO OF STUDENT
(OPTIONAL)

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 _____

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)**

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 separate puffs have been taken



If using **Bricanyl** (5 years or older)

- **Do not shake.** Open, twist around and back, and take a deep breath in
- Repeat until 2 separate inhalations have been taken

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