# Asthma care plan for education and care services

Photo of student (optional)

**Plan date**
___/___/20___

**Review date**
___/___/20___

**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 _____ Date of birth _____

## 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 (eg 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 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 _____

Date of approval: December 2016 | Approved by: CEO Asthma Australia | Date of review: July 2018 | AACPED2016 Care Plan for Ed-Care-Serv A4.indd | 07 March 2017