ASTHMA ACTION PLAN

(To be updated at least annually and as needed)

THE ASTHMA FOUNDATION Victoria

For children in childcare, kindergarten, family day care and out of school hours care

Instructions

1. To be completed by parents/guardians in consultation with their child's doctor.
2. Parents/guardians should inform their child's childcare service, kindergarten, family day care or out of school hours care immediately if there are any changes to this record.
3. Please tick the appropriate boxes or print your responses in the blank spaces where indicated

Privacy

The information on this Plan is confidential. All staff that care for your child will have access to this information. It will only be distributed to them to provide safe asthma management for your child. The service will only disclose this information to others with your consent if it is to be used elsewhere.

Child's name: .... Sex: M ☐ F ☐ Date of birth: ...../...../.....
(First Name) (Family Name)

PERSONAL DETAILS

Parent's/Guardian's Name: .....
Telephone: (H) ..... (W) ..... (M) .....
Emergency contact (e.g. parent/guardian): .....
Relationship: .....
Emergency contact telephone: (H) ..... (W) .....
(M) .....
Doctor: ..... Telephone: .....
Ambulance member: ☐ Yes ☐ No Membership number: .....

PHOTO

USUAL ASTHMA ACTION PLAN

Usual signs of child's asthma	Signs of child's asthma worsening	What triggers the child's asthma?
	Increased signs of:	
☐ Wheeze	☐ Wheeze	☐ Exercise
☐ Tightness in chest	☐ Tightness in chest	☐ Colds/Viruses
☐ Coughing	☐ Coughing	☐ Pollens
☐ Difficulty breathing	☐ Difficulty breathing	☐ Dust
☐ Difficulty speaking	☐ Difficulty speaking	☐ Smoke
☐ Other (Please specify)	☐ Other (Please specify)	☐ Pets
		☐ Other (Please specify)

Does the child tell the carer when they need medication? Yes ☐ No ☐

Does the child take any asthma medication before exercise/play? Yes ☐ No ☐

MEDICATION REQUIREMENTS USUALLY TAKEN IN CARE

(Include relievers, preventers, symptom controllers and combination medication before exercise).

Name of Medication (e.g. Ventolin, Flixotide)	**Method** (e.g. puffer & spacer)	**When and how much?** (e.g. one puff morning and night)

ASTHMA FIRST AID PLAN

Please tick your preferred Asthma First Aid Plan

☐ **4 STEP ASTHMA FIRST AID PLAN**

Step 1. Sit the person upright
- be calm and reassuring
- Do not leave them alone.

Step 2. Give medication
- Shake the blue reliever puffer
- Use a spacer and face mask if you have one, (use the puffer alone if a spacer and face mask are not available)
- Give 4 separate puffs into a spacer
- Take 4 breaths from the spacer after each puff

Giving blue reliever medication to someone who doesn't have asthma is unlikely to harm them

Step 3. Wait 4 minutes
- If there is no improvement, repeat steps 2.

Step 4 If there is <u>still</u> no improvement call emergency assistance **(DIAL 000).**
- Tell the operator the person is having an asthma attack
- Keep giving 4 puffs every 4 minutes while you wait for emergency assistance

Call emergency assistance immediately (DIAL 000) if the person's asthma suddenly becomes worse

OR

☐ **CHILD'S ASTHMA FIRST AID PLAN (approved by doctor)** (if different from above)

If the child's condition suddenly deteriorates or if at any time you are concerned — call an ambulance immediately (000).

- In the event of an asthma attack, I agree to my child receiving the treatment described above.
- I authorise children's services staff to assist my child with taking asthma medication should he/she require help.
- I will notify you in writing if there are any changes to these instructions.
- I agree to pay all expenses incurred for any medical treatment deemed necessary.
- Please notify me if my child has received asthma first aid.

Parent's/Guardian's Signature: _____ Date___/___/___

Doctor's Signature: _____ Date___/___/___

For further information please contact The Asthma Foundation of Victoria on (03) 9326 7088, toll free 1800 645 130, or visit our website www.asthma.org.au