

ASTHMA ACTION PLAN

(To be updated at least annually and as needed)



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

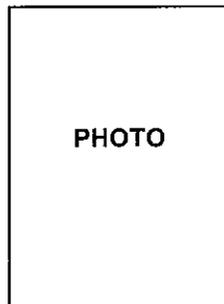
Privacy

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:



USUAL ASTHMA ACTION PLAN

Usual signs of child's asthma	Signs of child's asthma worsening	What triggers the child's asthma?
<input type="checkbox"/> Wheeze <input type="checkbox"/> Tightness in chest <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Other (Please specify)	Increased signs of: <input type="checkbox"/> Wheeze <input type="checkbox"/> Tightness in chest <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Other (Please specify)	<input type="checkbox"/> Exercise <input type="checkbox"/> Colds/Viruses <input type="checkbox"/> Pollens <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Pets <input type="checkbox"/> 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 <ul style="list-style-type: none">- be calm and reassuring- Do not leave them alone.
Step 2.	Give medication <ul style="list-style-type: none">- 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 <p>Giving blue reliever medication to someone who doesn't have asthma is unlikely to harm them</p>
Step 3.	Wait 4 minutes <ul style="list-style-type: none">- If there is no improvement, repeat steps 2.
Step 4	If there is <u>still</u> no improvement call emergency assistance (DIAL 000). <ul style="list-style-type: none">- 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 ___/___/___