

- Girraween Activity Centre
- Toongabbie West Activity Centre
- Beresford Road Activity Centre



Asthma Action Plan

Child's Name.....

This record is to be completed by parents/carers and their child's doctor. Parents/ carers should inform the service immediately if there are any changes to the management plan. Please tick the appropriate box, and print your answers clearly in the blank spaces where indicated.

Personal Details

Child's name Gender Male / Female

Date of Birth ___/___/___ School attending.....

Emergency Contact (parent, carer)

Name.....Phone.....relationship to child.....

Name.....Phone.....relationship to child.....

Doctor.....Phone.....

My Child's asthma action Plan

Child's symptoms (eg cough).....

Triggers (eg exercise, pollens).....

Medical requirements

Name of Medication	Method (eg puffer, spacer etc)	When and how much?

In an emergency, follow the asthma first aid plan below that has been ticked

- * My child's asthma action plan – note to parent – Full details must be included in plan, or staff will use the standard asthma plan above as set out by the Asthma foundation.

Or

- * Standard asthma first aid plan
 - Step 1 Sit the child upright, remain calm and provide reassurance. Do not leave the child alone.
 - Step 2 Give 4 puffs of a blue reliever puffer (airomir, asmol, epaq, or ventolin) one puff at a time, preferably through a spacer device. Ask the child to take 4 breaths from the spacer after each puff.
 - Step 3 If there is a little or no improvement, repeat steps 2 and 3
 - Step 4 if there is a little or no improvement, call an ambulance immediately (dial 000) continue to repeat steps 2 and 3 whilst waiting for the ambulance to arrive.
- Use a blue reliever puffer (airomir, asmol, epaq, or ventolin) on it's own if no spacer is available.

I authorise the staff at Activity Centres Inc. to follow the preferred asthma plan and assist my child with taking asthma medication should they require help. I will notify the centre in writing if there are any changes to these instructions. Please contact me if my child requires any type of treatment whilst in the centre's care.

Parents Name and Signature..... Date ___/___/___

Doctors Name and Signature..... Date ___/___/___