

Child Asthma Record

This record is to be completed by parents/carers OR their child's doctor (General practitioner).

Parents/carers should inform the school office 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: M F
(Surname) (Given names)

Date of birth: / / Grade: School:

Emergency Contact (eg parent or carer):

a Name Relationship

Telephone (home) Telephone (work/mobile)

b Name Relationship

Telephone (home) Telephone (work/mobile)

Doctor Telephone

Usual Asthma Management Plan

Child's Symptoms (eg cough)

Triggers (eg exercise, pollens)

Medication Requirements:

Name of Medication	Method (eg puffer & spacer, turbuhaler, autohaler)	When and how much?

In an **EMERGENCY**, follow the Plan below that has been ticked

Standard Asthma First Aid Plan

- Step 1** Sit the child upright, remain calm and provide reassurance. Do not leave 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 Wait 4 minutes.
Step 4 If there is little improvement, repeat steps 2 & 3.
If there is little or no improvement, call an ambulance immediately (Dial 000).
Continue to repeat steps 2 and 3 while waiting for the ambulance.

*Use a blue reliever puffer (Airomir, Asmol, Epaq or Ventolin) on its own if no spacer is available.

OR

My Child's Asthma First Aid Plan (full details must be attached or staff will use the standard 4 step plan)

Additional Comments:

I authorise the staff at the service to follow the preferred Asthma First Aid Plan and 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. Please contact me if my child requires emergency treatment or if my child regularly has asthma symptoms whilst attending the service.

Signature of Parent/Carer: Date:

I verify that I have read the preferred Asthma First Aid Plan and agree with its implementation.

OR

Signature of Doctor: Date: