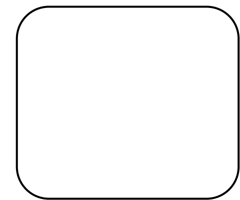
Child Asthma



Childs photo here

This record is to be completed by parents/carers and their child.s doctor (general practitioner).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: .... **Surname**...**Gender: M F**

Date of birth ....../....../...... School...................................
Emergency Contact (eg parent or carer):

Name...................... Relationship.........................

(Home) .... (Work)............................ (mobile)......................................

Extra contact Name............................... Relationship ....

Telephone .... (Home) .... (Work) .... (mobile)

Doctor... Telephone...............................

ALLERGY
Allergy Plan please attach doctors form
Child. Symptoms (eg cough) ....

Triggers (eg foods) ....

Medication Requirements:

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

In an EMERGENCY, follow the Plan below that has been ticked
Standard Asthma First Aid Plan Please tick the preferred

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Step 1 Sit the child upright, remain calm and provide reassurance. Do not leave child alone.
Step 2 Give 4 puffs of a blue relieverpuffer(Airomir,Asmol,EpaqorVetolin), one puff at a time, preferably througha spacer device*. Ask the child to take 4breathsfromthespaceraftereachpuffn.
Step 3 Wait 4 minutes.
Step 4 If there is little or no improvement, repeat steps 2 and 3. If there is still 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)

☐ **Or My child has their own plan attached.**

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:................