Roseville Kids Care
Child Asthma Record

This record is to be completed by parents/carers OR their child's doctor (GP). Parents/carers should inform the service immediately if there are any changes to the management plan.

Personal Details

Child's Name: _____   _____
(surname)   (given names)

Date of birth: ___ / ___ / ___

Emergency Contact (eg. parent or carer):

1. Name: _____   Relationship: _____

    Telephone: _____ (work)   Telephone: _____ (mobile)

2. Name: _____   Relationship: _____

    Telephone: _____ (work)   Telephone: _____ (mobile)

Doctor: _____   Telephone: _____

Usual Asthma Management Plan

Child's Symptoms (eg. cough): _____
_____

Triggers (eg. exercise, pollens): _____
_____

Medication Requirements:

Name of Medication	Method (eg. puffer & space)	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 *(Ventolin)*, one puff at a time, preferably through a spacer device. Ask the child to take 4 breaths from the space after each puff.
Step 3	Wait 4 minutes.
Step 4	If there is little or no improvement, repeat steps 2 and 3.
	If there is still no improvement, call an ambulance immediately (Dial 000).
	Continue to repeat steps 2 and 3 while waiting for the ambulance.

Roseville Kids Care
Child Asthma Record (cont')

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 of Roseville Kids Care to follow my 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 Roseville Kids Care.

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: _____