S D
(A)

CONFIDENTIAL: Staff are trained in asthma first aid (see overleaf) and can provide routine asthma medication as authorised in this care plan by the treating doctor. Please advise staff in writing of any changes to this plan.

To b compl t d by th tr ating doctor and par nt/guardian, for sup rvising staff and m rg ncy m dical p rsonn l.

PLEASE PRINT CLEARLY

Plan date
___/___/20__

Review date
___/___/20__

DOB:

This stud nt's usual asthma signs:

- Cough
- Wheeze
- Difficulty breathing
- Other (please describe):

Fr qu ncy and s v rity:

- Daily/most days
- Frequently (more than 5 x per year)
- Occasionally (less than 5 x per year)
- Other (please describe)

Known trigg rs for this stud nt's asthma (.g. x rcis *, colds/flu, smok) — pl as d tail:

DOCTOR

Name of doctor

Address

Phone

Signature Date

EMERGENCY CONTACT INFORMATION

Contact name

Phone

Mobile

Email