

Childcare Asthma Record Card

This record is to be completed by parents in consultation with their child's doctor (general practitioner). Parents should inform their child's childcare service, kindergarten or preschool immediately if there are any changes to the management plan. Please tick the appropriate box, and print your responses in the blank spaces where indicated. For some questions you may need to tick more than one box.

Childs name: _____ **Sex:** M F
 (Surname) (First Name)

Personal Details

Date of birth. / / Carer:

Emergency Contact (eg parent /guardian)

a Name..... Relationship
 Telephone (Home) Telephone (Work)

b Name..... Relationship
 Telephone (Home) Telephone (Work)

Doctor Telephone

Usual Asthma Management Plan

Child's Symptoms (eg cough)

Triggers (eg exercise, pollens)

Medication Requirements:

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

Does your child tell you when he/she needs asthma medications? Yes No

Does your child need assistance to take asthma medications? Yes No

Does your child take medications before exercise/play? Yes No

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

Standard Asthma First Aid Plan Please tick the preferred box

- 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** 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.

OR

My Child's Asthma First Aid Plan (attached)

Additional Comments:

.....

I authorise staff to follow the preferred Asthma First Aid Plan and assist my child with taking asthma medication should they 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 in care

Signature of Parent/Carer: **Date:**

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

Source: The Children's Asthma Resource Pack for Parents and Carers, June 2006
NSW Paediatric Network



The Children's Hospital at Westmead
Tel: (02) 9845 3585
Fax: (02) 9845 3562
<http://www.chw.edu.au/>

Sydney Children's Hospital,
Randwick
Tel: (02) 9382 1688
Fax: (02) 9382 1451
<http://www.sch.edu.au/>

Kaleidoscope, Hunter Children's
Health Network
Tel: (02) 4921 3670
Fax: (02) 4921 3599
www.kaleidoscope.org.au

© The Children's Hospital at Westmead, Sydney Children's Hospital, Randwick and Kaleidoscope – Hunter Children's Health Network- 2005-2006.