

Attach photo here


ICS Asthma Care Plan

Students Name	Admissions Number		Date of Birth
Wears medical ID (delete as appropriate)	Yes/No	Weight (for medication dosage)	kg
Parent/Guardian Name	Mobile Number		Relationship
Parent/Guardian Name	Mobile Number		Relationship
Emergency Contact	Mobile Number		Relationship
Medical Contact Name/ Treating Doctor	Telephone		Facility
Permission to discuss with education staff: Yes/No			
Your child's sign of an asthma attack			
Date/age diagnosed? _____			
Your child's triggers (things that make their asthma worse)			
Does your child say when they need their medication?			Yes / No
Does your child need help taking their asthma medication?			Yes No
Does your child need to take any medicine before exercise? Please include on prescription sheet			Yes / No
School held medication/information (please attach doctor's prescription and medical report)			
Parents need to supply supplies of medication for the school clinic in the event of emergency and loss of hand held medication (if prescribed). No student should be carrying medication without the prior knowledge of the school nurse. Student's inhalers will be stored in the Clinic in an accessible place to be used in emergencies only. It is parents responsibility to update the school nurse with any medical details and healthcare requirements during the school year.			



Should _____ suffer from an asthma attack with no school nurse present, I give permission for any of the adults working with them to administer the inhaler provided. This will be done in their capacity as a responsible adult rather than a qualified medical practitioner. First aiders will have been given instruction by the school nurse prior to any trip/activities. We understand that we will be informed directly of this. I agree that the school and its employees shall not be liable for any claims that I may have arising from the administration of this medicine to my child at school or on trips/activities.

Parents Full Name (please print)	Parents Signature	Date
Nurses Full Name (please print)	Nurses Signature	Date

Reliever medication for _____

Mild Symptoms		Action
<ul style="list-style-type: none"> • Coughing • Shortness of breath • Wheeze • Tightness of chest • Fatigue • Increased breathing rate 		<ul style="list-style-type: none"> • Inform school nurse if on site • Assist the child (if needed) to take two puffs of their reliever inhaler, preferably through a spacer (as prescribed) • Sit the child up and encourage them to take slow and steady breaths • Wait 15 minutes and if symptoms improved allow child to return to class/activity

If no improvement in symptoms

Moderate Symptoms		Action
<ul style="list-style-type: none"> • Complaints of chest tightness • Pale, quiet and withdrawn • Breathlessness causes problems with speech • Flared nostrils • Mouth breathing • Rapid breathing 		<ul style="list-style-type: none"> • Child takes two puffs of reliever inhaler every two minutes • One puff at a time • Via spacer • They can take up to ten puffs • Contact parent/guardian
Severe Symptoms		Action
<ul style="list-style-type: none"> • Too breathless to speak a full sentence • Pale and grey • Floppy or unresponsive • Very rapid breathing rate • Severe tugging in at the neck or between ribs 		<ul style="list-style-type: none"> • Dial 998 for an ambulance • Add: ICS CAMPUS ADDRESS • Contact parent/guardian • Administer reliever inhaler as above up to ten times whilst waiting for help

Additional Information