This record is to be completed in consultation with the participant and/or nominee and their doctor.   
Please tick the appropriate box and print your answers clearly in the blank spaces where indicated. The information on this Plan is confidential. All staff who care for this participant will have access to this information. Kyeema will only disclose this information to others with your consent if it is to be used elsewhere. Please contact Kyeema at any time if you need to update this Plan or you have any questions about the management of asthma at Kyeema.

|  |  |  |  |
| --- | --- | --- | --- |
| **My Name:** |  | **Date of Birth** |  |
| **Date Plan Written:** |  | **Date to Review:** |  |
|  | | | |
| **Emergency Contact Details** | | | |
| **Name:** |  | | |
| **Address:** |  | | |
| **Home Phone:** |  | **Mobile:** |  |
|  | | | |

**MY USUAL ASTHMA SUPPORT PLAN**

**Usual signs of my asthma: (please circle)**

Wheeze Tight Chest Cough Difficulty breathing Difficulty talking   
  
Other………………………………………………………………………………………………………………………..

**Signs my asthma is getting worse: (please circle)**

Wheeze Tight Chest Cough Difficulty breathing Difficulty talking   
  
Other………………………………………………………………………………………………………………………..

**My Asthma Triggers: (please circle)**

Cold/flu Exercise Smoke Pollens Dust   
  
Other…………………………………………………………………………………………………………………….….

**My Asthma Medication** (Including relievers, preventers, symptom controllers, combination)

|  |  |  |
| --- | --- | --- |
| Name of Medication  (e.g. Ventolin,Flixotide) | Method  (e.g. puffer & spacer) | When and how much?  (e.g. before exercise) |
|  |  |  |
|  |  |  |
|  |  |  |

Do I need assistance taking my medication? **Yes** **No** If yes, how? ...........................................................

.............................................................................................................................................................................

|  |
| --- |
| **Managing Exercise Induced Asthma (EIA)** |
| If exercise is a trigger for this participant they should follow these steps to prepare for exercise: |
| * Take the blue reliever or doctor recommended medication 5-10 minutes before warm up. Warm up appropriately before exercise or activity and always cool down following activity and be alert for asthma symptoms after exercise. |
| If a participant gets EIA during exercise they should: |
| * Stop the exercise or activity and refer to the participant’s asthma first aid plan (on next page). If their symptoms reoccur, recommence treatment. DO NOT RETURN TO ACTIVITY for the rest of the day and inform the parent/carer of any incident. |

**ASTHMA FIRST AID PLAN**

*Please tick preferred Asthma First Aid Plan*

🞎 **Kyeema Support Services Inc. Policy for Asthma First Aid**

1. Sit participant upright, remain calm and reassure them. Do not leave participant alone.
2. Without delay shake a blue reliever puffer (e.g. Asmol or Ventolin) and give 4 separate puffs through a spacer (use the puffer alone if a spacer is not available). Give one puff at a time and ask the participant to take 4 breaths from the spacer after each puff.
3. Wait 4 minutes.
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) and state that the participant is having an asthma attack. Continuously repeat steps 2 and 3 while waiting for the ambulance.

**If at any time the participant’s condition suddenly worsens, or you are concerned, call an ambulance immediately.**

**OR**

🞎 **My Asthma First Aid Plan** *(if different from above)*

* If I receive Asthma First Aid, please notify: .
* In the event of an asthma attack, I agree to receiving the treatment described above.
* I authorise Kyeema staff to assist me with taking asthma medication should I require help.
* I (or my Nominee or doctor) will notify you if there are any changes to these instructions.
* I agree to pay any expenses incurred for any medical treatment deemed necessary.

Participant’s Signature: ................................................................ Date...../..../.....

(If applicable) Nominee’s Signature: ....................................................................... Date..../..../....

For further information about asthma management please visit www.asthma.org.au

**PARTICIPANT NAME**:

**PLAN DATE**:

# Staff acknowledgement

I have read and understood the ASTHMA Support Plan for this participant.

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Worker Name** | **Worker Signature** | **Date** |
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