Child Asthma Record

This form is to be completed by parents/carers in consultation with the child's doctor (general practitioner or specialist). Parents/carers should inform the service immediately if there are any changes to the child's asthma management. A new Asthma Record should be provided at the beginning of each year. Please tick the appropriate box, and print your answers clearly in the blank spaces where indicated.

Personal Details

Child's Name _____ (first name) _____ (last name)

Gender ☐ Male ☐ Female Date of Birth __ __ / __ __ / __ __ __ __

Name of Children's Service _____

Emergency Contacts (e.g. Parent or carer)
1. Name _____ Relationship _____
Telephone (Daytime) _____ (Home) _____
2. Name _____ Relationship _____
Telephone (Daytime) _____ (Home) _____

Doctor's Contact Details Name _____ Telephone _____

Asthma Management Plan

Does the child tell the carer when he/she needs medication? ☐ Yes ☐ No

Child's Symptoms (eg cough) _____

Triggers (eg exercise, pollens) _____

Medication Requirements: (Parents need to supply asthma medication eg, puffer and spacer)

Name of Medication	Method of delivery (eg puffer & spacer)	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 and remain calm and provide reassurance. Do not leave the child alone.

Step 2: Give 4 puffs of a blue reliever (Airomir, Asmol, Epaq or Ventolin), one puff at a time, 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.

*Use a blue reliever (Airomir, Asmol, Epaq or Ventolin) on its own if no spacer is available.

☐ **My Child's Asthma First Aid Plan** as written in consultation with my child's doctor.

(full details must be attached or staff will use the above Standard Asthma First Aid Plan)

Additional Comments: _____

_____

I authorise the staff at the service to follow the 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 the service.

Signature of Parent/Carer _____ Date _____

Signature of Child's Doctor _____ Date _____