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

Cough

DOB:

S D A)

Plan date ___/___/20___

Review date ____/___/20___

This stud nt's usual asthma signs: Fr qu n

Fr qu ncy and s v rity:

Daily/most days

Known trigg $\,$ rs for this stud $\,$ nt's asthma ($\,$.g. $\,$ x $\,$ rcis $\,$ *, colds/flu, smok) -

pl as d tail:

Wheeze Frequently (more than 5 x per year)

Difficulty breathing Occasionally (less than 5 x per year)

Other (please describe): Other (please describe)

DOCTOR

Name of doctor

Address

Phone

Signature Date

EMERGENCY CONTACT INFORMATION

Contact name

Phone

Mobile

Email