Fairview Community Primary School

ASTHMA CARE PLAN

Child Name: _____

Care Plan Review Date:

Medication Expiry Date:

DAILY ASTHMA MANAGEMENT

This child's usual asthma signs:	**Frequency and severity:**	**Known Triggers (eg cold, exercise)**
☐ Cough	☐ Daily/most days	_____
☐ Wheeze	☐ Frequently (more than x 5 a yr)	_____
☐ Difficulty breathing	☐ Occasionally (less than x 5 a yr)	_____
☐ Other (please describe)	☐ Other (please describe)	_____
_____	_____	_____
_____	_____	_____

Does this pupil usually tell an adult if she/he is having trouble breathing? **Yes / No**
Does this pupil need help to take asthma medication? **Yes / No**
Does this pupil use a mask with a spacer? **Yes / No**
Does this student need a blue/grey reliever puffer medication before exercise? **Yes / No**

NAME OF MEDICATION & COLOUR	DOSE/NO OF PUFFS	TIME REQUIRED

Emergency Contact:

Name: _____

Contact Number: _____

Relationship to child: _____

Parent Signature: _____

GP Information:

Surgery: _____

Tel No: _____

Date: _____