

List anything else which makes your child's asthma worse or triggers an asthma attack (Eg colds, cigarette smoke)

1. _____
2. _____
3. _____
4. _____

It is not possible to avoid all triggers so sometimes symptoms may be worse than others. When this happens it is important to follow the Asthma Emergency Advice Leaflet. You will be given this along with _____'s Care Plan.

General

Name: _____

Phone: _____

Date: ____/____/____

Practice Nurse:

Name: _____

Phone: _____

Care Plan Review due

Date: ____/____/____

- Contact your practice nurse if you are unsure or worried about what to do
- Please contact the surgery if this plan is lost

Copy to patient record

For further information please contact your local asthma society



THE LUNG ASSOCIATION

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Asthma New Zealand/The Lung Association
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Name: _____

Asthma Care Plan



**Keep this care plan in a handy place.
(Perhaps on the fridge or on a notice-board in the kitchen or with the child's medication)**

Asthma Care Plan

Asthma is a condition, which may cause your child to have difficulty breathing or to develop a troublesome cough to the point where it disturbs their sleep. These symptoms can be very distressing for your child. To help your child be as well as possible and enjoy life, it is important that your child's asthma is well controlled.

To help achieve this make sure that

_____ takes her/his medication as prescribed and uses the inhaler correctly. Your practice nurse will help you with this.

Please bring this Care Plan with you whenever your child comes to see the practice nurse or the doctor.



Date _____

Name _____

D.O.B _____

Height: _____ Weight _____

Your child has been prescribed the following medication to help control their asthma symptoms

1. _____

This is called a **Preventer** medicine and needs to be taken **every day** through a spacer.

Preventer Device _____

Strength _____

Dose _____ puff(s) twice a day
(every 12 hours)

2. _____

This is called a **Reliever** medicine and needs to be taken when your child has asthma symptoms.

Reliever Device _____

Strength _____

Dose _____ puff(s) 4 times a day
(every 6 hours if child needs it for symptoms)



Date Spacer provided: _____

Points to Note

Has (name) _____ had a Skin Prick Test for allergies?

Yes

No

If yes please list **ALL** known allergies below
