Cherrybrook Technology High School

28-44 Purchase Road
Cherrybrook NSW 2126

Telephone
02 9484 2144

Email
cths@cths.nsw.edu.au

Website
https://cths.nsw.edu.au

Principal
Mr M Townsend

Deputy Principals
Mr B Clements
Mrs A Gatt
Mr M Fisher

May 2024

Medical Information Request for
Students with a Health Condition

Dear Parents/Carers

Cherrybrook Technology High School is currently reviewing all student health care plans and updating Individual Health Care Plans as per Department of Education policy.

If your child has a health condition which may require support at school or when involved in school activities, for example school excursions, the enclosed **Individual Health Care Plan Cover Sheet** and **Parent consent for a doctor to provide information about their child's heath condition** must be completed by parents and carers.

These conditions include **Anaphylaxis, Severe Asthma and Serious Medical Conditions** (eg Diabetes, Epilepsy etc).

While the main role of the school is to provide education, we would like to support you by keeping your child healthy and safe at school.

Please complete and sign these forms, on the basis of information provided by your doctor.

We ask you to please **return the attached information to the school via email - only if your child has a serious medical condition.**

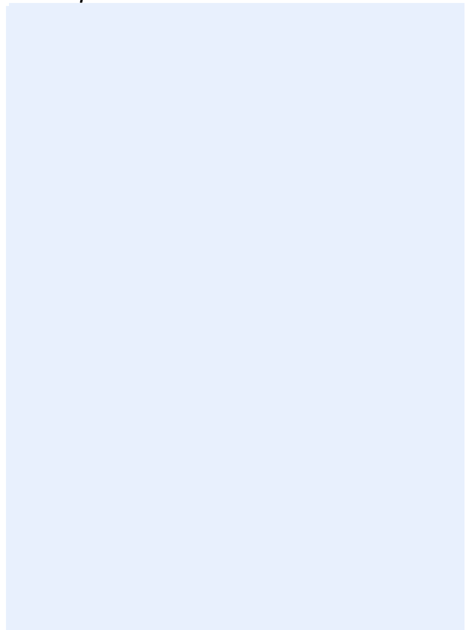
Please advise the Head Teacher Wellbeing at any time if there are changes to the information about your child's health care needs at peter.hind@det.nsw.edu.au

Yours sincerely

Mr Matt Townsend
Principal

Mr Peter Hind
Head Teacher Wellbeing

Insert photo of student



Individual Health Care Plan Cover Sheet

This template forms the cover sheet for an individual health care plan. Additional information and attachments will be relevant to meet the specific health care needs of the student.

The individual health care plan must address the needs of the student in the context of the school and the activities the student will be involved in. Planning must take into account the student's full range of learning and support needs.

The individual health care plan is developed in consultation with the parent, staff and student, where practicable, and on the basis of information from the student's doctor, provided by the parent.

For more information see http://www.schools.nsw.edu.au/studentsupport/studenthealth/index.php and for students with anaphylaxis see the Anaphylaxis Procedures for Schools.

The plan will be reviewed on:

NOTE: Individual health care plans should be reviewed at least annually or when the parent notifies the school that the student's health needs have changed. Principals can also instigate a review of the health care plan at other times.

School	Cherrybrook Technology High School		**Phone**	9484 2144
Principals Network	Hills Network			
Student name			**Class**	
Date of birth		**Medicare number**		
ERN/Student number				
Health condition/s				
If anaphylaxis, list the confirmed allergies				
Learning and support needs of the student (including learning difficulties, behaviour difficulties and other disabilities)				
Impact of any of the conditions (as mentioned above) on implementation of this individual health care plan				
Medication/s at school				

<table>
<tr><td>Medication supply, storage and replacement. For anaphylaxis this will include the adrenaline autoinjector</td><td colspan="2"></td></tr>
<tr><td>Other support at school</td><td colspan="2"></td></tr>
<tr><td rowspan="16">Parent/Carer contacts:</td><td colspan="2">Parent/Carer information (1)</td></tr>
<tr><td>First name</td><td></td></tr>
<tr><td>Surname</td><td></td></tr>
<tr><td>Relationship to child</td><td></td></tr>
<tr><td>Address</td><td></td></tr>
<tr><td>Home phone</td><td></td></tr>
<tr><td>Work phone</td><td></td></tr>
<tr><td>Mobile phone</td><td></td></tr>
<tr><td colspan="2">Parent/Carer information (2)</td></tr>
<tr><td>First name</td><td></td></tr>
<tr><td>Surname</td><td></td></tr>
<tr><td>Relationship to child</td><td></td></tr>
<tr><td>Address</td><td></td></tr>
<tr><td>Home phone</td><td></td></tr>
<tr><td>Work phone</td><td></td></tr>
<tr><td>Mobile phone:</td><td></td></tr>
<tr><td rowspan="7">Emergency contacts (if parent/carer unavailable)</td><td>First name</td><td></td></tr>
<tr><td>Surname</td><td></td></tr>
<tr><td>Relationship to child</td><td></td></tr>
<tr><td>Address</td><td></td></tr>
<tr><td>Home phone</td><td></td></tr>
<tr><td>Work phone</td><td></td></tr>
<tr><td>Mobile phone</td><td></td></tr>
</table>

Medical practitioner / doctor contact:	First name	
	Surname	
	Address	
	Phone	
	Mobile (if known)	
	Email (if known)	
	Fax (if known)	

Emergency Care

Notes:

An emergency care/response plan is required if the student is diagnosed at risk of a medical emergency at school. For students at risk of anaphylaxis the ASCIA Action Plan for Anaphylaxis is the emergency response plan. This plan is obtained by the parent from the student's doctor and not developed by the school.

Emergency Service Contacts: (eg ambulance, local hospital, medical centre)
1.
2.
3.
In the event an ambulance is called, schools can print an ambulance report from within ERN for the student.

Special medical notes

Any special medical notes relating to religion, culture of legal issues, eg. Blood transfusions.

Note: If the student is transferred to the care of medical personnel, eg. Paramedics this information, will if practicable in the circumstances, be provided to those personnel. It will be a matter for the professional judgment of the medical personnel whether to act on the information.

Documents attached

Please tick which of the following documents are attached as part of the individual health care plan:

☐ An emergency care/response plan (for anaphylaxis this is the ASCIA Action Plan for Anaphylaxis)

☐ A statement of the agreed responsibilities of different people involved in the student's support

☐ A schedule for the administration of prescribed medication

☐ A schedule for the administration of health care procedures

☐ An authorisation for the doctor to provide health information to the school

☐ Other documents – please specify. *Note: For anaphylaxis this should include strategies to minimise the risk of exposure to known allergens and details of communication and staff training strategies. See the Anaphylaxis Procedures for Schools for further information*.

Consultation This individual health care plan has been developed as part of the learning support plan, in consultation with those indicated below and overleaf and with the knowledge and agreement of the student's parent/carer. Information has been provided by: ☐ Student ☐ Parent/Carer ☐ GP ☐ Medical Specialist	
Department staff involved in plan development	
1. Peter Hind	Phone: 9484 2144
2. Alison Gatt	Phone: 9484 2144
3. Joanne Ede	Phone: 9484 2144
4.	Phone:
5.	Phone:
Health care personnel involved in managing the student's health at school: (eg Community Nurse, Therapist)	
1.	Phone:
2.	Phone:
3.	Phone:
4.	Phone:
Signature of Parent/Carer:	Date
Signature of Head Teacher Wellbeing, Mr Peter Hind:	Date
NOTES: *Information in this individual health and emergency care plan remains specific to meet the needs of the individual student named and should not be applied to the care of any other student with similar health and emergency care needs. All individual health and emergency care plans must take into account issues of confidentiality and privacy to ensure information about the student is treated appropriately.* *The school and the Department are subject to the Health Records and Information Privacy Act 2002. The information on this form is being collected for the primary purpose of ensuring the health and safety of students, staff and visitors to the school. It may be used and disclosed to medical practitioners, health workers including ambulance officers and nurses, government departments or other schools (government and non-government) for this primary purpose or for other related purposes and as required by law. It will be stored securely in the school.*	

Parent consent for a doctor to provide information about their child's health condition

This form is to be completed by the parent.

My child, ______________________________________, is currently enrolled or applying for enrolment at Cherrybrook Technology High School.

I understand the school may need to discuss the implications of my son/daughter's medical condition so the school can provide support for him/her during school hours.

I give my permission for the doctor named below to give the school information about how to manage my son/daughter's health condition at school.

Doctor's information:

Name: ____

Address: ____

____

Phone:____

Email: ____

Fax:____

I understand the information given may be discussed by the Principal of the school with other members of school staff, as is necessary, enabling staff to care for my child.

Parent/Carer's Name: ____

Parent/Carer's Signature: __________________________________ Date: ____________

Student Medical Information Booklet

Cherrybrook Technology High School

Please Complete this Booklet for Students with Health Conditions &/or Allergies

Students with any health conditions &/or allergies including, asthma, anaphylaxis, diabetes, epilepsy, learning disorders etc:

1. **Parent/Carer** to complete the **Authorisation to Contact Doctor** section (Appendix 2).

Students with a **Mild or Moderate Allergy**:

1. **Parent/Carer** to complete the **Students with Allergies** section (Appendix 1)
2. **Doctor** to complete the **green ASCIA Action Plan for Allergic Reactions** (included). MUST BE **COLOURED** COPY!

Students with **Anaphylaxis**:

1. **Doctor** to complete the **Students with Allergies** sections (Appendix 1 & 3)
2. **Doctor** to complete the **red ASCIA Action Plan for Anaphylaxis** (included). MUST BE **COLOURED** COPY!

Students with **Asthma**:

1. **Doctor** to complete the **Asthma** section of Appendix 3
2. **Doctor** to complete the **blue Asthma Action Plan** (included).

3 April 2024

Appendix 1: Students with Allergies

This form is to be completed by the student's Parent / Carer, then returned promptly to the school's First Aid Officer.

The purpose of collecting this information is to identify students who are at risk of a severe allergic reaction. Information provided on this form will be used to assist the school in determining what action needs to be taken in relation to a student with an allergy and may be disclosed where required by law (for example if an ambulance is called to the school).

Student's full name: ____ DOB:____________

1. A Doctor has diagnosed my child with an allergy to:
   - ☐ Insect bite / sting (please specify): ____
   - ☐ Medication (please specify): ____
   - ☐ Latex
   - ☐ Other (please specify): ____
   - ☐ Food
     - Peanuts Yes ☐ No ☐
     - Tree nuts Yes ☐ No ☐

     (if yes, please specify):____
     - Fish Yes ☐ No ☐
     - Shellfish Yes ☐ No ☐
     - Soy Yes ☐ No ☐
     - Sesame Yes ☐ No ☐
     - Wheat Yes ☐ No ☐
     - Milk Yes ☐ No ☐
     - Egg Yes ☐ No ☐
     - Other (please specify): ____

2. My child has been prescribed an adrenaline autoinjector (EpiPen® or Anapen®).
   Yes ☐ No ☐

3. My child has a **red** ASCIA Action Plan for Anaphylaxis (please attach and return with this form).
   Yes ☐ No ☐

4. My child has a **green** ASCIA Action Plan for Allergic Reactions (please attach and return with this form).
   Yes ☐ No ☐

5. My child has an ASCIA Action Plan for Drug (medication) Allergy (please attach and return with this form).
   Yes ☐ No ☐

I understand my child is responsible for carrying their adrenaline autoinjector, as well as their ASCIA Action Plan for Anaphylaxis, at all times.

The school also requires you to provide an extra adrenaline autoinjector for your child in case of an emergency, which will be stored in a central location within the school.

Each time your child is prescribed a new adrenaline autoinjector, the Doctor will also issue you with an updated ASCIA Action Plan for Anaphylaxis. To ensure your child's safety, the updated adrenaline autoinjector and plan must be provided promptly to the school, as well as carried by your child.

Parent / Carer's full name: ____

Parent / Carer's signature: ____

Date: ______________________

Appendix 2: Authorisation to Contact Doctor

This form is to be completed by the Parent / Carer.

Student's full name: ____ DOB:____________

My child is currently enrolled or applying for enrolment at Cherrybrook Technology High School.

I understand:

1. The school may need to discuss the implications of my child's medical condition(s) with their treating Doctor, so the school can develop and implement an Individual Health Care Plan.

2. The information which may be sought by the school, includes information about my child's allergy and risk of anaphylaxis and any other condition which might impact on the school providing support for my child during school hours and during activities conducted under the care of the school.

3. Information provided by the Doctor to the school may be used or disclosed by school staff for the purposes of the development or implementation of the Individual Health Care Plan. I understand, the Department of Education / school can contact my child's Doctor to seek information to assist in the management of my child's medical condition at school.

4. I consent to the health care professional identified below, to provide the Department of Education / school with information about my child's allergy, risk of anaphylaxis and any other condition, including a learning disorder, which might impact on the school providing support for my child during school hours and during school-related activities.

Doctor's information:

Name: ____

Address: ____

Phone: ____

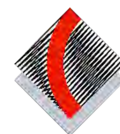
Mobile (if known): ____

Email (if known): ____

Parent / Carer's full name: ____

Parent / Carer's signature: ____

Date: ______________________



Appendix 3: Allergies - Information from the Doctor

This form is to be completed by the Doctor. Information provided will be used for the development of the student / patient's Individual Health Care Plan used by their school.

Please provide the appropriate ASCIA Action Plan for Anaphylaxis or ASCIA Action Plan for Allergic Reactions for this patient, **completed and signed**. The plans can be accessed from the ASCIA website at http://www.allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis.

Please complete all parts of the plans so the Parent / Carer can take them to their child's school for use as the school's emergency response plan.

Please include other information or details you believe are important in managing the severe allergy at school and during activities conducted under the care of the school. The additional information requested below will further assist the school in the development of the student's Individual Health Care Plan.

Student's full name: ____ DOB:____________

1. Does the student / patient have asthma?

Yes ☐ No ☐

2. Does the student / patient have any other health conditions?

Yes ☐ No ☐

If yes, please specify: ____

____

3. Does the student / patient have any other conditions which may impact on their ability to understand the nature of their anaphylaxis and the risk it poses to them. For example, developmental delay, language challenges, neurodiversity, behaviour challenges?

Yes ☐ No ☐

If yes, please specify: ____

____

4. Have you discussed the condition(s) with the student / patient and their Parent / Carer?

Yes ☐ No ☐

If you require further information, please phone the school on 9484 2144 and speak to the First Aid Officer.

Doctor's Information:

Name: ____

Address: ____

Phone: ____

Mobile (if known): ____________________________________

Email (if known): _____________________________________

Fax (if known): _______________________________________

Doctor's signature: ____________________________________

Date: ______________________

Parent / Carer's Declaration:

I consent to this information being provided for the school's use so they can develop an Individual Health Care Plan for my child.

I understand my child is responsible for carrying their adrenaline autoinjector, as well as their ASCIA Action Plan for Anaphylaxis and / or asthma medication and plan, at all times.

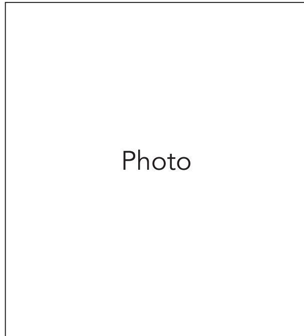
Parent / Carer's full name: _____________________________

Parent / Carer's signature: _____________________________

Date: ______________________

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR
Allergic Reactions



Name: ______________________ Date of birth: DD / MM / YYYY

Confirmed allergen(s): ______________________

Family/emergency contact(s):

1. ______________________ Mobile: ______________________
2. ______________________ Mobile: ______________________

Plan prepared by: ______________________ (doctor or nurse practitioner)
who authorises medications to be given, as consented by the patient or parent/guardian, according to this plan.

Signed: ______________________ Date: DD / MM / YYYY

Antihistamine: ______________________ Dose: ______________________

This plan does not expire but review is recommended by: DD / MM / YYYY

This ASCIA Action Plan for Allergic Reactions is for people who have allergies but do not have a prescribed adrenaline (epinephrine) injector.

MILD TO MODERATE ALLERGIC REACTIONS

SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

Mild to moderate allergic reactions may not always occur before anaphylaxis

ACTIONS:

- Stay with person, call for help
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

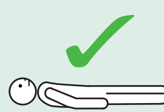
Watch for ANY ONE of the following signs:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)

ACTIONS FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



2 GIVE ADRENALINE INJECTOR IF AVAILABLE

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

Adrenaline injector doses are:

- 150 mcg for children 7.5-20kg
- 300 mcg for children over 20kg and adults
- 300 mcg or 500 mcg for children and adults over 50kg

Instructions are on device labels.

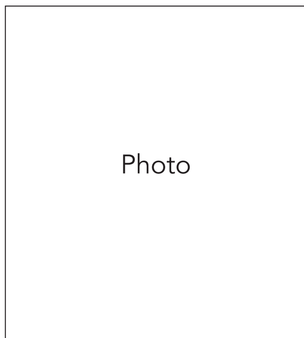
ALWAYS GIVE ADRENALINE INJECTOR FIRST and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

© ASCIA 2023 This plan is a medical document that can only be completed and signed by the patient's doctor or nurse practitioner and cannot be altered without their permission.

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis



Name: ______________________ Date of birth: DD / MM / YYYY

Confirmed allergen(s): ______________________

____

Family/emergency contact(s):

1. ______________________ Mobile: ______________________

2. ______________________ Mobile: ______________________

Plan prepared by: ______________________ (doctor or nurse practitioner) who authorises medications to be given, as consented by the parent/guardian, according to this plan.

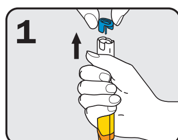
Signed: ______________________ Date: DD / MM / YYYY

Antihistamine: ______________________ Dose: ______________________

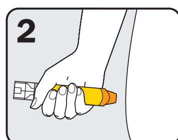
This plan does not expire but review is recommended by: DD / MM / YYYY

How to give adrenaline (epinephrine) injectors

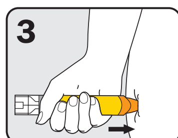
EpiPen®



Form fist around EpiPen® and PULL OFF **BLUE** SAFETY RELEASE



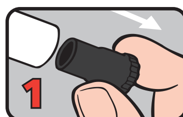
Hold leg still and PLACE **ORANGE** END against outer mid-thigh (with or without clothing)



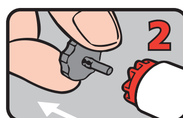
PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds REMOVE EpiPen®

EpiPen® is prescribed as follows:
EpiPen® Jr (150 mcg) for children 7.5-20kg
EpiPen® (300 mcg) for children over 20kg and adults

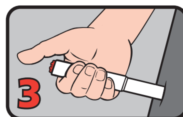
Anapen®



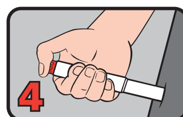
PULL OFF **BLACK** NEEDLE SHIELD



PULL OFF **GREY** SAFETY CAP from red button



PLACE NEEDLE END FIRMLY against outer mid-thigh at 90°angle (with or without clothing)



PRESS **RED** BUTTON so it clicks and hold for 3 seconds. REMOVE Anapen®

Anapen® is prescribed as follows:
Anapen® 150 Junior for children 7.5-20kg
Anapen® 300 for children over 20kg and adults
Anapen® 500 for children and adults over 50kg

MILD TO MODERATE ALLERGIC REACTIONS

SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

Mild to moderate allergic reactions may not always occur before anaphylaxis

ACTIONS:

- Stay with person, call for help
- Locate adrenaline injector
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

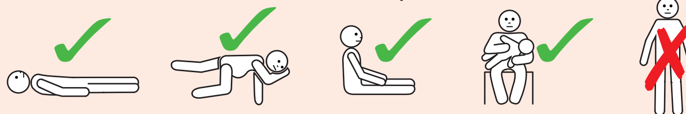
Watch for ANY ONE of the following signs:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)

ACTIONS FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



2 GIVE ADRENALINE INJECTOR

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS GIVE ADRENALINE INJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

If adrenaline is accidentally injected, phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

© ASCIA 2023 This plan is a medical document that can only be completed and signed by the patient's doctor or nurse practitioner and cannot be altered without their permission.

ASTHMA ACTION PLAN

Take this ASTHMA ACTION PLAN with you when you visit your doctor

ACTION PLAN FOR

Name ....

Date ....

Next asthma check-up due ....

DOCTOR'S CONTACT DETAILS

Name ....

Phone ....

EMERGENCY CONTACT DETAILS

Name ....

Phone ....

Relationship ....

WHEN WELL

Asthma under control (almost no symptoms)

ALWAYS CARRY YOUR RELIEVER WITH YOU

Your preventer is: ....
(NAME & STRENGTH)

Take .... puffs/tablets .... times every day

- ☐ Use a spacer with your inhaler

Your reliever is: ....
(NAME)

Take .... puffs ....

When: You have symptoms like wheezing, coughing or shortness of breath

- ☐ Use a spacer with your inhaler

Peak flow* (if used) above:

OTHER INSTRUCTIONS
(e.g. other medicines, trigger avoidance, what to do before exercise)

....

....

....

....

WHEN NOT WELL

Asthma getting worse (needing more reliever than usual, having more symptoms than usual, waking up with asthma, asthma is interfering with usual activities)

Keep taking preventer: ....
(NAME & STRENGTH)

Take .... puffs/tablets .... times every day

....

- ☐ Use a spacer with your inhaler

Your reliever is: ....
(NAME)

Take .... puffs ....

....

- ☐ Use a spacer with your inhaler

Peak flow* (if used) between and

OTHER INSTRUCTIONS ☐ Contact your doctor
(e.g. other medicines, when to stop taking extra medicines)

....

....

....

....

IF SYMPTOMS WORSEN

Severe asthma flare-up/attack (needing reliever again within 3 hours, increasing difficulty breathing, waking often at night with asthma symptoms)

Keep taking preventer: ....
(NAME & STRENGTH)

Take .... puffs/tablets .... times every day

....

- ☐ Use a spacer with your inhaler

Your reliever is: ....
(NAME)

Take .... puffs ....

....

- ☐ Use a spacer with your inhaler

Peak flow* (if used) between and

OTHER INSTRUCTIONS ☐ Contact your doctor today
(e.g. other medicines, when to stop taking extra medicines)

Prednisolone/prednisone:

Take .... each morning for .... days

....

....

....

DANGER SIGNS

Asthma emergency (severe breathing problems, symptoms get worse very quickly, reliever has little or no effect)

DIAL 000 FOR AMBULANCE

Peak flow (if used) below:

Call an ambulance immediately
Say that this is an asthma emergency
Keep taking reliever as often as needed

- ☐ Use your adrenaline autoinjector (EpiPen or Anapen)

National Asthma Council AUSTRALIA

nationalasthma.org.au

* Peak flow not recommended for children under 12 years.

ASTHMA ACTION PLAN

WHAT TO LOOK OUT FOR

WHEN WELL

THIS MEANS:
- you have no night-time wheezing, coughing or chest tightness
- you only occasionally have wheezing, coughing or chest tightness during the day
- you need reliever medication only occasionally or before exercise
- you can do your usual activities without getting asthma symptoms

WHEN NOT WELL

THIS MEANS ANY ONE OF THESE:
- you have night-time wheezing, coughing or chest tightness
- you have morning asthma symptoms when you wake up
- you need to take your reliever more than usual
- your asthma is interfering with your usual activities

THIS IS AN ASTHMA FLARE-UP

IF SYMPTOMS GET WORSE

THIS MEANS:
- you have increasing wheezing, cough, chest tightness or shortness of breath
- you are waking often at night with asthma symptoms
- you need to use your reliever again within 3 hours

THIS IS A SEVERE ASTHMA ATTACK (SEVERE FLARE-UP)

DANGER SIGNS

THIS MEANS:
- your symptoms get worse very quickly
- you have severe shortness of breath, can't speak comfortably or lips look blue
- you get little or no relief from your reliever inhaler

CALL AN AMBULANCE IMMEDIATELY: DIAL 000
SAY THIS IS AN ASTHMA EMERGENCY

DIAL 000 FOR AMBULANCE

ASTHMA MEDICINES

PREVENTERS

Your preventer medicine reduces inflammation, swelling and mucus in the airways of your lungs. Preventers need to be taken **every day**, even when you are well.

Some preventer inhalers contain 2 medicines to help control your asthma (combination inhalers).

RELIEVERS

Your reliever medicine works quickly to make breathing easier by making the airways wider.

Always carry your reliever with you – it is essential for first aid. Do not use your preventer inhaler for quick relief of asthma symptoms unless your doctor has told you to do this.

To order more Asthma Action Plans visit the National Asthma Council website.
A range of action plans are available on the website –
please use the one that best suits your patient.

nationalasthma.org.au

National Asthma Council Australia retained editorial control. © 2023

National Asthma Council AUSTRALIA