

ASTHMA MANAGEMENT PLAN

Confidential



To be completed by the parent/guardian of a child who suffers from Asthma.

A. Student Details

Surname: _____ Given Names: _____

Date of Birth: ____ / ____ / ____ Year level in 2008: _____

Male: Female:

Home Phone: _____

Mother's Work: _____ Mother's Mobile: _____

Father's Work: _____ Father's Mobile: _____

B. Medical Information

Name of Doctor treating your child for Asthma: _____ Phone: _____

HOW SEVERE IS YOUR CHILD'S ASTHMA?

Your child requires Asthma medication most weeks of the year: Yes / No

Your child wakes regularly at night with Asthma? Yes / No

Has your child required urgent medical attention for Asthma in the past year? Yes / No

Is your child's peak flow consistently below expected, despite optimal treatment? Yes / No

PEAK FLOW:

Does your child have a peak flow meter? Yes / No

If yes, will they bring it to camp? Yes / No

What is their normal reading? _____

WHAT ARE THE TRIGGER FACTORS FOR YOUR CHILD'S ASTHMA?

Is your child's Asthma triggered by any of the following factors?

Dust Yes / No Pollens Yes / No

Plants Yes / No Moulds Yes / No

Animal Fur Yes / No Fuel fumes Yes / No

Cold conditions Yes / No Exercise Yes / No

Food preservatives Yes / No (Specify) _____

Flavourings (eg MSG) Yes / No (Specify) _____

Artificial food Yes / No (Specify) _____

Specific food / food groups Yes / No (Specify) _____

(eg. Wheat or dairy products)

Any other known triggers or additional information:



MANAGEMENT PLAN

In order to give assistance to a student in distress, we need the following information and a preventative plan of management.

Summarise a preventative plan of management to undertake during camp to prevent the onset of a major attack.

What are the warning signs for the onset of a major attack?

Outline the best strategies for obtaining relief of the attack.

WHAT ASTHMA MEDICATION DOES YOUR CHILD TAKE?

Please circle the Preventer or Reliever (Bronchodilator) medication used by your child.

Preventers: Becotide Becloforte Aldecin Pulmicort Intal or Intal Forte
Other (please specify): _____

Relievers Bricanyl Respolin Ventolin Atrovent
Other (please specify): _____

Parent/Guardian Signature: _____ **Date:** _____