# ASTHMA MANAGEMENT PLAN

To be completed by the parent/guardian of a child who suffers from asthma. If your child does not suffer from asthma, please disregard this form.

<table>
<thead>
<tr>
<th>Students name:</th>
<th>Male / Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian phone no: Home</td>
<td>Work</td>
</tr>
</tbody>
</table>

### Medical Information:

<table>
<thead>
<tr>
<th>Name of Doctor treating your child for asthma:</th>
<th>Ph:</th>
</tr>
</thead>
</table>

### HOW SEVERE IS YOUR CHILD'S ASTHMA?

<table>
<thead>
<tr>
<th>Your child requires asthma medication most weeks of the year?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child wakes regularly at night with asthma?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Has your child required urgent medical attention for asthma in the past year?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Is your child’s peak flow consistently below expected, despite optimal treatment?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

### PEAK FLOW

<table>
<thead>
<tr>
<th>Does your child have a peak flow meter?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is their normal reading?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Dust</th>
<th>Yes / No</th>
<th>Pollens</th>
<th>Yes / No</th>
<th>Plants</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moulds</td>
<td>Yes / No</td>
<td>Animal Fur</td>
<td>Yes / No</td>
<td>Fuel Fumes</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Cold Conditions</td>
<td>Yes / No</td>
<td>Exercise</td>
<td>Yes / No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Food Preservatives**

**Flavourings (e.g. MSG)**

**Artificial food**

**Specific food or food groups (e.g. wheat or dairy products)?**

Any other known triggers of additional information?

| __________________________________________ | __________________________________________ |
| __________________________________________ | __________________________________________ |

### Plan of Management:

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

**Summarise a prevention plan of management to undertake 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 medication used by your child)

**Preventers:**

Becotide, Becloforte, Aldecin, Pulmicort, Intal, or Intal Forte

Other (please specify) __________

**Reliever:**

Bricanyl, Respolin, Ventolin, or Atrovent

Other (please specify) __________

Please indicate if you would like your child’s asthma medication to be kept in the health room or with them at all times

| __________________________________________ |

Date: ____________________________ Signed: ____________________________