Asthma Management Plan

Member's Name: _____

Age: _____ Date of Birth: _____

Parent's / Guardian's Names:_____

Address:_____

Phone: Home _____Work:_____ Mobile:_____

Emergency Contact Name:_____ Phone: _____ Mobile: _____

Doctor's Name:_____ Phone: _____

Doctor's
Address:_____

Medicare
Number:_____

Ambulance Subscriber: YES / NO Subscriber No: _____

Please answer all Questions in detail:

1. What are your child's trigger factors?_____

_____

2. Does your child suffer from any allergies? _____

_____

3, Does your child have any particular dietary requirements? If YES please describe.

_____

_____

4. Is medication usually required? YES / NO (If yes pls fill in table below)

Medication	Dosage	How Often and When?	Method

5. Does your child use a Peak Flow Meter?

If YES: please write readings below:

Lowest Reading:_____ Highest Reading:_____

6. Does your the child need pre exercise medication? YES / NO
(If yes please provide the following information)

Medication:_____

Dosage: _____

7. Does your child require assistance/supervision from leaders while taking medication? YES / NO
(If yes , please provide instructions)

Instructions:_____

_____

_____

8. Any other Information that will assist leaders/instructors to manage your child's asthma?

_____

_____

DECLARATION:
In the event of an asthma attack whilst at dancing, I agree to my son/ daughter receiving treatment described above and/ or any other medical attention deemed necessary by a Medical practitioner. I agree to pay all expenses incurred for any medical treatment deemed necessary including calling an ambulance.

Parent's/ Guardian's Signature_____ Date: _____

I understand that it is my responsibility to notify Verchovyna Administration of any changes to these details

EMERGENCY ACTION PLAN
This section is to be completed by the participant's Doctor in consultation with their Parent or Guardian.

1. What are the child's usual symptoms of Asthma? (✓)
   Wheezing ■ Tightness in chest ■ Coughing ■ Difficulty in breathing ■

   Other please specify:_____

2. What are the child's signs / symptoms of worsening Asthma?

   Please describe:_____

3. Has the child been admitted to hospital due to Asthma in the past 12 months?
   Yes / No

4. Has the child ever had a sudden severe attack requiring hospitalisation?
   Yes / No

5. Has the child been on oral corticosteroids (eg prednisolone) in the last 12 months?
   Yes / No

6. Please tick the preferred Emergency Plan:

Standard Victorian Schools Asthma Policy for Emergency treatment of an Asthma Attack.

1. Sit child down and remain calm to reassure student.
2. Without delay give 4 PUFFS of a reliever inhaler : (Ventolin Respolin Asmol or Bricanyl) using a spacer .
3. Wait 4 minutes. If there is no improvement give another 4 puffs as per step 2.
4. If no improvement call an ambulance (Dial 000) immediately and state that " a child is having an Asthma attack."
5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

Child's Emergency Treatment (If different from above)

Medication	Dosage	Method	How Often

Comments:

Doctor's Approval:
The above management plan is provided for _____ . His / her asthma is under control .
Doctor's comment (if any):

Doctor's Signature: **Date:**