

60-ЛІТТЯ УКРАЇНСЬКОЇ МОЛОДІ



КРАЙОВИЙ ТАБІР 2007-2008



Asthma Management Plan

Participant'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 the child's trigger factors? _____

2. Does the child suffer from any allergies? _____

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

4. Is medication usually required daily? YES / NO

If YES: please fill in the table:

Medication	Dosage	How Often and When?	Method

5. Does the child use a Peak Flow Meter?

If YES: please write their readings below:

Lowest Reading: _____ Highest Reading: _____

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

Medication: _____

Dosage: _____

Under What circumstances? (eg. Running)

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

Instructions: _____

8. Any other Information that will assist the leaders to manage your child's Asthma?

DECLARATION:

In the event of an asthma attack while at camp, 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 the Camp Leadership & Administration of any changes to these details

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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: