



ASTHMA MANAGEMENT FORM

This record is to be completed by parents or guardians in consultation with their child’s doctor

Child’s first name:	
Child’s last name:	
Date of birth:	
Age:	
Parent/ guardian’s full name:	

USUAL ASTHMA MANAGEMENT PLAN

Usual signs of child’s asthma	Worsening signs	What triggers?
<i>Increased signs of:</i>		
Wheezing <input type="checkbox"/> Tightness in chest <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Difficulty in speaking <input type="checkbox"/> Other (please describe) <input type="checkbox"/>	Wheezing <input type="checkbox"/> Tightness in chest <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Other (please describe) <input type="checkbox"/>	Exercise <input type="checkbox"/> Colds / viruses <input type="checkbox"/> Pollens <input type="checkbox"/> Dust <input type="checkbox"/> Food <input type="checkbox"/> Which foods? <input type="checkbox"/> Other triggers (please describe)

Does your child need assistance taking their medication? YES NO

Any other information that will assist with the asthma management of the child while on camp.

Medication requirements – including preventers, symptom controllers, medication before exercise

Medication name	Method (i.e. puffer and spacer, turbuhaler)	When and how much?