Asthma Management Form

The following confidential information is required to assist in the proper management of a child's asthma, if such help is needed. Please complete and attach to the Medical Consent form. For more information on Asthma see section 4.5.10.3 of the Victorian Government Schools’ Reference Guide. Further information is available from the Asthma Foundation www.asthma.org.au.

Student's name:

School:

Usual signs of asthma: □ Wheezing □ Chest tightness □ Coughing □ Difficulty breathing □ Difficulty speaking □ Other

When completing this form please seek the advice of the asthmatic's doctor if necessary.

1. Usual maintenance regime or medical program followed:

   Name of Medication  Method (eg. Puffer & spacer, turbohaler)  When and how much?

   Does the child require assistance to take their medication? □ Yes □ No

2. Peak flow readings: Best ................................Critical ..........................(bring own peak flow meter)

3. Signs of worsening asthma: □ Wheezing □ Chest tightness □ Coughing □ Difficulty breathing □ Difficulty speaking □ Other:

   Medication and treatment to be used during worsening asthma:

4. Medication and treatment to be used during crisis situations:

   See Asthma First Aid Plan attached on page 2.

5. List any known asthma trigger factor(s):

6. Has the person been admitted to hospital due to asthma in the past 12 months? □ Yes □ No
7. Has the person been on oral cortisone for asthma within the past 12 months? (e.g. Prednisolone, Cortisone, Betamethasone etc) □ Yes □ No
8. Has the person ever suffered sudden severe asthma attacks requiring hospitalisation? □ Yes □ No

Important Notes
If you have answered “yes” to questions 6, 7, or 8 then the decision for the person to participate rests with the child’s doctor. The process in such situations is as follows:
The person's doctor or parents/guardians (if a student) may contact the school Principal for further information on the program and support available;
a letter from the student's doctor, stating the doctor's decision must accompany this form.

I declare that the information provided on this form is complete and correct.

Parent/guardian: __________________________

Phone contact(s): __________________________

Signature: __________________________ Date: ___________ 

Asthma First Aid Plan

- SIT: the student down and reassure
- ASSESS: severity of attack
- CHECK: personal Asthma Action Plan (if any)

4 separate puffs of blue reliever via spacer

4 minutes Relief

4 separate puffs of blue reliever via a spacer

4 minutes Relief

Call an ambulance
State is an asthma attack
Repeat 4 separate puffs every 4 minutes while waiting

From the Victorian Government Schools' Reference Guide Section 4.5.7.8