



**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?