

**LILYDALE HIGH SCHOOL**  
***Outdoor Education/Duke of Edinburgh Award***  
**Asthma Management Form - Confidential**

Participant's name: \_\_\_\_\_ Form: \_\_\_\_\_

Your Doctor's / Asthma specialist's name: \_\_\_\_\_ Contact ☎: \_\_\_\_\_

*Please seek the advice of your Doctor when completing this form.*

1. Usual maintenance medical program followed by the asthmatic:

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Preventer medication is: \_\_\_\_\_ Reliever Medication is: \_\_\_\_\_

2. Peak Flow Readings: Best: \_\_\_\_\_ Critical: \_\_\_\_\_ (Bring Own Peak Flow Meter)

3. Medication and treatment regime to be used during and emergency asthma attack

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4. List any known asthma **trigger factors** experienced by the asthmatic:

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**KEY QUESTIONS:**

- |   |  |
|---|--|
| 5. Has asthma interfered with participation in normal physical activities within the past 12 months?                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Has the participant been admitted to hospital due to asthma in the past 12 months?                                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc)? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Has the participant suffered sudden severe asthma attacks requiring hospitalisation within the past 12 months?     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Does the participant require the use of a nebulising pump as part of your regular or emergency asthma treatment?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |

**IMPORTANT NOTES:**

If any of the KEY QUESTIONS 5, 6, 7, 8 or 9 above are answered "Yes", the decision for the participant to attend programs rests with their doctor in consultation with the school. A "FITNESS TO PARTICIPATE FORM" MUST BE completed by the Doctor (see attached). Please bring this form to the Doctor with you.

The "FITNESS TO PARTICIPATE FORM" should be attached to the medical and "ASTHMA MANAGEMENT FORM" and returned to the school. Please update the school immediately if your child's medical condition alters.

I declare that the information provided on this form is complete and correct. I give permission for the school and it's representatives to pass this information onto a third party (e.g. Doctor, Hospital) to facilitate the medical treatment of my child (or myself for adults).

Parent / Guardian's Name: \_\_\_\_\_ Contact ☎: \_\_\_\_\_

Parent's / Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_