Asthma Management Form

Participant’s Name: 

Name of doctor treating the participant for this condition:  

Doctor’s Contact Phone Number: 

1) **USUAL ASTHMA ACTION PLAN**

*Usual signs of participant’s asthma:*

- [ ] Wheeze  
- [ ] Tight Chest  
- [ ] Cough  
- [ ] Difficulty breathing  
- [ ] Difficulty talking  
- [ ] Other ____________

*Signs participant’s asthma is getting worse:*

- [ ] Wheeze  
- [ ] Tight Chest  
- [ ] Cough  
- [ ] Difficulty breathing  
- [ ] Difficulty talking  
- [ ] Other ____________

*Participant’s Asthma Triggers:*

- [ ] Cold/flu  
- [ ] Exercise  
- [ ] Smoke  
- [ ] Pollens  
- [ ] Dust  
- [ ] Other (please describe) ____________

2) **ASTHMA MEDICATION REQUIREMENTS** (Including relievers, preventers, symptom controllers, combination)

<table>
<thead>
<tr>
<th>Name of Medication (e.g. Ventolin, Flixotide)</th>
<th>Method (e.g. puffer &amp; spacer, turbuhaler)</th>
<th>When and how much? (e.g. 1 puff in morning and night, before exercise)</th>
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Does the participant need assistance taking their medication? Yes No  
If yes, how? ____________

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

E.g. peak expiratory flow, night time asthma or recent attacks

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2) **ASTHMA FIRST AID PLAN** (Please tick preferred Asthma First Aid Plan)

- [ ] School Asthma Policy for Asthma First Aid

**Step 1.** Sit the person upright
- Be calm and reassuring
- Do not leave them alone.

**Step 2.** Give medication
- Shake the blue reliever puffer
- Use a spacer if you have one
- Give 4 separate puffs into a spacer
- Take 4 breaths from the spacer after each puff

*You can use a Bricanyl Turbuhaler if you do not have access to a puffer and spacer.*

Giving blue reliever medication to someone who doesn’t have asthma is unlikely to harm them.

**Step 3.** Wait 4 minutes
- If there is no improvement, repeat steps 2.

**Step 4.** If there is still no improvement call emergency assistance (DIAL 000).
- Tell the operator the person is having an asthma attack
- Keep giving 4 puffs every 4 minutes while you wait for emergency assistance

Call emergency assistance immediately (DIAL 000)

If the person’s asthma suddenly becomes worse.
3) **KEY QUESTIONS**

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<table>
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<tr>
<td>a. Has asthma interfered with participation in physical exercise within the past 12 months</td>
<td>NO [ ] YES [ ]</td>
<td></td>
</tr>
<tr>
<td>b. Has the participant required hospitalization due to asthma in the past 12 months?</td>
<td>NO [ ] YES [ ]</td>
<td></td>
</tr>
<tr>
<td>c. Has the participant been on oral cortisone for asthma within the past 12 months (e.g. Prednisone, Cortisone, etc)?</td>
<td>NO [ ] YES [ ]</td>
<td></td>
</tr>
<tr>
<td>d. Has the participant suffered sudden severe asthma attacks requiring hospitalisation within the past 12 months?</td>
<td>NO [ ] YES [ ]</td>
<td></td>
</tr>
<tr>
<td>e. Does the participant require the use of a nebulising pump as a part of your regular or emergency asthma treatment?</td>
<td>NO [ ] YES [ ]</td>
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</tbody>
</table>

4) **IMPORTANT NOTES**

*If any of the "KEY QUESTIONS" a, b, c, d, or e above are answered "Yes", the decision for the participant to attend rests with their Doctor. A “Fitness to Participate” form must be completed by the Doctor (attached). Please bring this form to the Doctor with you.*

The Fitness to Participate form should be attached to the medical and asthma management forms and returned to school.

I declare that the information provided on this form is complete and correct and that I will notify the school if any changes occur. I further declare that if my child (or I for adults) is unable to self administer supplied medication, I give permission for trained OEG staff to administer the supplied emergency medication. I give permission for OEG to pass this information to a third party [e.g. Doctor, Hospital] to facilitate the medical treatment of my child (or myself for adults). I give permission for OEG to retain this form for statutory archival requirements, noting that I can access it by appointment as per Privacy Policy documented on our website: (oeg.org.au).

Name: ___________________________ Signature: _____________________ Date:  _______________
Fitness to Participate Form

School Name: _____________________________  Year Level: ____________

Name of Participant: _________________________  D.O.B. ______________________________

Specific Medical Condition: (e.g. Asthma, Allergies) ______________________________________

Notes to treating Doctor
This patient is scheduled to participate in an Outdoor Education program and has self-identified a pre-existing medical condition on their medical form.

Outdoor Education programs with OEG are centred in a ‘semi-wilderness’ setting, meaning that professional medical care may be from 1 to 6 hours away. All programs include regular physical exercise and activities may include bushwalking (with packs), camping, cycling, rock climbing or canoeing. We operate in all weather conditions. (Should you require any further information on the program, please contact us at (02) 4878 5393 and quote the name of the client organisation and year level listed at the top of this page)

OEG staff hold a Wilderness First Aid qualification (minimum of 7 days training). This training is based on assessing and treating a patient in a remote or wilderness setting. For more information see http://www.wms.org/

Doctor to complete:
Based on this information above and the patient’s condition, we ask that you decide on this person’s suitability to participate in the upcoming program. If approved, please include specific treatment protocols to follow in the event of an emergency.

Do you approve this participant attending an Outdoor Education program, based on their current medical condition, coupled with the demands of the program?

☐ Yes  ☐ No

What treatment protocol are you willing to authorize for this patient in the case of a medical emergency, in a remote location (i.e. one or more hours away from medical care)?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What should the OEG staff managing this participant in the field be informed/aware of, in regards to the particular situation for this patient? What are the recommended parameters for participation in the activities?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Name of Doctor: _____________________________  Phone: _____________________________

Signature of Doctor: _____________________________  Date: _____________________________

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