CRAIGIEBURN PRIMARY SCHOOL
Student Medical Condition Form

Year:

Student Name:	**Grade:**

ASTHMA MEDICAL CONDITION DETAILS:

Answer the following questions **ONLY** if the student suffers from any asthma medical conditions.

Please indicate if the student suffers from any of the following symptoms: (tick)	**If my child displays any of these symptoms please:** (tick)		
☐ Cough	Inform Doctor	☐ Yes	☐ No
☐ Difficulty Breathing	Inform Emergency Contact	☐ Yes	☐ No
☐ Wheeze	Administer Medication	☐ Yes	☐ No
☐ Exhibits symptoms after exertion	Other Medical Action	☐ Yes	☐ No
☐ Tight Chest	If yes, please specify:		

Has an Asthma Management Plan been provided to School?			☐ Yes	☐ No
Does the student take medication? (tick)	☐ Yes ☐ No	**Name of medication taken:** *		
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)		☐ Preventative	☐ Response	
Indicate the usual dosage of medication taken: *		**Indicate how frequently the medication is taken:**		
Medication is usually administered by: (tick)	☐ Student	☐ Nurse	☐ Teacher	☐ Other
Medication is stored: (tick)	☐ with Student	☐ with Nurse	☐ Fridge in Staff Room	☐ Elsewhere
Dosage time	**Reminder required?** (tick) ☐ Yes ☐ No	**Poison Rating**		

Other Medical Condition Details:

Medical Condition			
Further Detail:			
Symptoms		**On display of symptoms:**	
		Inform Doctor? Y or N	
		Inform Emergency Contact Y or N	
		Administer Medication Y or N	
		Other Medical Action Y or N	
Medication		**Dosage**	
Frequency		**Administer By:**	
Location Stored		**Dosage Time**	
Reminder Required Yor N		**Poison Rating**	

Parent/Guardian Signature: _____ Date: _____