Asthma Record and Medication in School

Child's Full Name _____ Class _____

Emergency Contact: Name _____

Telephone _____

Doctor's Name _____

Doctor's Address _____

Doctor's Telephone No. _____

Details of Condition _____

Details of Asthma medication to be taken at school – PLEASE MAKE SURE THE ACTUAL INHALER HAS YOUR CHILDS NAME ON IT NOT JUST THE BOX

1. Name and type of medication _____

Dose to be given and when _____

Is this medication to be taken regularly in school? Y/N

Is this medication to be taken as relief treatment when needed i.e. for sudden chest tightness, wheezing, breathlessness? Y/N

Procedure for asthma sufferers:

If no relief or symptoms reappear: - Call Parent/Carer

If child's condition deteriorates: - Dial 999 for an ambulance or take to nearest hospital

- Call Parent/Carer

Please state how independent your child is in administering their own inhaler medication

_____

_____

I agree to members of staff administering the **measured dose requested** of the aforementioned medicine to my child.

Parent's Signature _____

Date _____

As with all medication held in school it is the parents' responsibility to check the expiry date and availability of their child's medication.