

Asthma Medication Form



Name of Child Date:

PLEASE STATE WHICH INHALERS ARE LIKELY TO BE NEEDED IN SCHOOL AND THE LIKELY INDICATIONS FOR USE (i.e. before games/going out in cold air/during a bad cold etc.)

Inhaler Type: Spacer included: YES / NO

Reasons for Use:

Time of Usage: Number of Puffs required:

Has your child got a self-management plan? (If yes, please attach copy). YES / NO

If your child is experiencing asthma symptoms and their inhaler is empty, do you give permission for the school to use its generic Salbutamol inhaler and/or spacer? YES / NO

Please give details of **two contact numbers** to be used in an emergency:

1. Name: Mobile No:

2. Name: Mobile No:

Name of GP: Tele No:

Name of Asthma Nurse: Tele No:

Parental Consent

I being the parent/guardian of understand that I am responsible for ensuring that my child is equipped with their asthma medication as required.

I consent to my child being given extra relief medication using the school's emergency inhaler and/or spacer in the event of my child suffering an asthma attack.

I understand that the school's emergency inhaler and/or spacer will only be used in the event of an emergency where larger doses of medication are deemed necessary.

I understand that I shall be informed if my child's asthma appears to be deteriorating in school, so that I can inform my child's GP and/or Asthma Nurse as necessary.

Ensure that if your child is admitted to hospital as a result of an asthma attack in school, please notify the school office.

Signed: Parent/Guardian

Date: