

Dear Parent/Guardian/Carer

SCHOOL ASTHMA CARE PLAN

NAME OF CHILD:D.O.B.

ADDRESS:

.....

TELEPHONE: ab

GP's NAME:

DESCRIPTION OF TREATMENT:

.....

I undertake to inform the school immediately if my child's medication/treatment is changed.

I confirm that:

- a. My child is able to take responsibility for the self-administration of his/her asthma medication and is able to carry his/her asthma device at school.
- b. My child is not able to self-administer his/her asthma medication and will require assistance.

(Please delete a or b as applicable)

- c. My child's inhaler is named

Signed:Date:

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

I understand my child will be given relief medication using the inhaler held by the school in the event of him or her suffering an asthma attack.

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 General Practitioner or Practice Nurse as necessary.

Signed: Date:
(Parent/Guardian)