Thomas Adams School

Asthma Health Care Plan

Childs Name	
Date Of Birth	
Group/ Class/ Form	
Child's Address	
Date Asthma Diagnosed	

Family Contact Information

Parents/ Guardians Name	
Phone Number: Home	
Work	
Mobile	
Phone Number: Home	
Work	
Mobile	

G.P.

Name	
Phone Number	

Hospital/ Clinic Contact

Name	
Phone Number	

Describe home the asthma affects your child including their typical symptoms and asthma 'triggers'

Describe their daily care requirements including the name of their asthma medicine(s), how often it is used and the dose (e.g. once or twice a day, just when they have asthma symptoms, before sport)

Describe what an asthma attack looks like for your child and the action to be taken if this occurs

Who is to be contacted in an emergency? Give three contact telephone numbers

Name	Number

Form Copied to: (to be completed by the school asthma lead)

ADVICE FOR PARENTS

Remember:

1. **It is your responsibility to tell the school about any changes in your child's asthma and/ or their asthma medication**
2. **It is your responsibility to ensure that your child has their 'relieving' medication with them in school and that it is clearly labelled with their name**
3. **You should confirm this with your child's class teacher**
4. **It is your responsibility to ensure that your child's asthma medication has not expired**
5. **Your child should not be exposed to cigarette smoke**

The Thomas Adams School

Request for a child to carry their own medication

Parents complete this form

If staff have any concerns about any of the information required for this form they should discuss this with the staff nurse

Name of school	
Childs name	
Group/class/form	
Child's address	
Name of medication	
Procedures to be taken in an emergency	

Contact information

Name	
Daytime phone number	
Relationship to child	

I would like my son/daughter to keep their medicine themselves for use as necessary.

Signed: _____

Print name: _____

Relationship to child: _____

Date: _____

Thomas Adams School

Parental Agreement for School to Administer Medicine

The school will not give your child medicine unless you complete and sign this form

Childs name	
Date Of Birth	
Group / class / form	
Medical condition or illness	
Name and phone no. of GP	
Name/type of medicine (as described on the container)	
Dosage and method	
Are there any side effects that the school need to know about	
Procedures to take in an emergency	

Contact Details

Name	
Daytime telephone number	
Relationship to child	
Address	

I accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school of any changes to my child's medication in writing.

Date: _____ Signature: _____

Please note: IT is your responsibility to ensure that the school is kept informed about changes to your child's medicines, including how much they take and when. It is also your responsibility to provide the school with medication that is clearly labelled and in date.

CONSENT FORM:

USE OF EMERGENCY SALBUTAMOL INHALER

The Thomas Adams School

Child showing symptoms of asthma/ having an asthma attack

1. I can confirm that my child has been diagnosed with asthma / has been prescribed and inhaler [delete as appropriate].
2. My child has a working, in date inhaler, clearly labelled with their name, which they will bring with them to school every day.
3. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school* for such emergencies.

Signed _____

Date: _____

Name (Print): _____

Childs name: _____ Form: _____

Parent's address and contact details:

_____
_____
_____
_____

Telephone: _____

Email: _____

*If your child uses a school inhaler, please could you go to your GP and ask for a replacement, Thank you.