ST. WALBURGA'S R. C. PRIMARY SCHOOL

ASTHMA RECORD FORM

Any history past or present of Asthma and medication

Child's Name ..... D.O.B. .....

Address..... Tel No. .....

Emergency Phone No. ..... G. P. .....

Regular treatment to be taken in school time:

Name of Medicine Dose: Time Taken

Type of inhaler used: Trigger factors : (if known)

Relief Treatment when needed for sudden chest tightness, wheeze, breathlessness, cough: give or allow child to take:

Medication and how taken Dose and when taken

PLEASE NOTE THE FOLLOWING: (Special instructions to school staff)
(i.e. inhaler to be used prior to P.E. lessons)

I understand that it is my responsibility to provide the class teacher with inhaler devices (clearly labelled) and to check them regularly.

I give my permission for school staff to administer medication as they think necessary

I accept that I must inform the school in writing of any alteration to the inhaler type or dosage.

Signed ..... Parent/Guardian

Date .....