ASTHMA EMERGENCY INFORMATION

This plan should be produced by parents, school and the specialist/school nurse and if necessary a copy sent to the child’s GP.

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| --- | --- | --- |
| Child’s Name |  | Child’s Photo |
| Class/form |  |  |
| Date of Birth |  |
| School Year |  |
| Parent/Carer Name(s) |  |
| Home Contact Number |  |
| Mobile Contact Number |  |
| GP/Medical Centre Number |  |
| School Nurse Number |  |

|  |  |
| --- | --- |
| Known triggers |  |

|  |  |
| --- | --- |
| Location of medication in school |  |

|  |  |
| --- | --- |
| Designated school health official |  |

|  |  |
| --- | --- |
| Instructions for reliever inhaler use (please tick the appropriate statement) | |
|  | My child does **not** understand the proper use of his/her inhaler and requires help to administer them. |
|  | My child understands the proper use of his/her asthma medications and, in my opinion, can carry and use their inhaler at school independently; notifying the designated health official after using their inhaler. |

I give permission for school personnel to share this information with all school staff, follow this plan and administer medication.

If necessary, I also give permission for the school to contact our GP/School Nurse and in the case of an emergency, this plan may be passed to medical professionals.

I assume full responsibility for providing the school with prescribed medication and delivery devices and if necessary I give permission for the school to use the emergency inhaler if required. I approve this Asthma Care Plan for my child.

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| Parent/s Signature |  | Date |
| Health Care Practitioner Signature |  | Date |
| Headteacher’s Signature |  | Review Date |