St Catherine's C of E School

School Asthma Care Plan

DETAILS OF PUPILS

Name ……

Address…… M/F: ……

……

Date of Birth: …… Class: ……

Name of GP: …… Tel: ……

MEDICATION – Name/Type of Medication (as described on the container)

……

Date Dispensed by chemist: ……

Date of annual review (to be completed by Office staff) ……

Dosage and method: ……

Timing: ……

Any additional information: ……

Please confirm that:

a. My child is able to administer his/her asthma medication independently.

b. my child will require assistance to administer his/her asthma medication.

Delete as appropriate

PARENT/CARER CONTACT DETAILS:

Name …… Daytime Telephone No ……

I understand that I must deliver the medicine personally to the Class Teacher. I will undertake to name all medication for quick identification and periodically check with the teacher that it is still in date. I will let the school know immediately if my child's medication is changed or is no longer required.

Date: …… Signature: ……