The Suffolk Schools Asthma Policy

Name of child: …… Date of Birth: ……..…….

PLEASE STATE WHICH INHALERS/MEDICINES ARE LIKELY TO BE NEEDED IN SCHOOL AND THE LIKELY INDICATIONS FOR USE

(ie Relievers: before games/going out into cold air/during a bad cold etc - Preventers: child is using four times a day etc)

INHALER: ……..

LIKELY REASONS FOR USE: ……..

……..……

……..……

INHALER/MEDICINE: ……

LIKELY REASONS FOR USE: ……..

……..……

……..……

INHALER/MEDICINE: ……

LIKELY REASONS FOR USE: ……..

……..……

……..……

Has your child got a self-management plan? YES / NO

Has your child been prescribed a metered dose reliever inhaler to be used with the school's emergency spacer in the event of a severe attack? YES / NO

Please give details of TWO contact numbers to be used in an emergency:

1. Name: …… Tel No: ……

1. Name: …… Tel No: ……

Name of GP: ……..…… Tel No: ……..……

GP Asthma Practice Nurse: ……..……

PLEASE SIGN DISCLAIMER OVERLEAF

I, the parent/guardian of the child named overleaf, request and give permission for the Headteacher, or person acting on his/her authority, to administer the above medication in accordance with the directions given. I understand that neither the Headteacher nor anyone acting on his/her authority, nor the Governing Body nor Suffolk County Council will be liable for any illness or injury to the child arising from the administering of the medicine or drug unless caused by the negligence of the Headteacher, the person acting on his/her authority, the Governing Body or Suffolk County Council, as the case may be.

Signed: …… Date: ……

Relationship to Pupil: ……