

# SCHOOL ASTHMA CARE PLAN

NAME OF CHILD..... D.O.B.....

ADDRESS.....

TELEPHONE.....

G.P.s NAME..... TEL.....

DESCRIPTION OF TREATMENT.....

.....

I undertake to inform the school immediately if my child's medication/treatment is changed.

I confirm that:-

- a. My child is able to take responsibility for the self-administration of his/her asthma medication
- b. My child is not able to self-administer his/her asthma medication and will require assistance

**Please delete a. or b. as applicable**

- c. My child's inhaler is named

Signed..... Date.....