Dear Parent/Carer,

***RE: The School Asthma Health Care Plan Register***

Our school has an Asthma Health Care Plan which allows us as a school to best understand your child’s asthma.

Could you please fill in the enclosed Asthma Care Plan along with the permission to give medication at school. This allows us to give your child the emergency inhaler that we keep in school. This is not a replacement for their own inhaler but one that can be used if their own inhaler has run out or has been lost on the way to school or around school.

All pupils with an individual Asthma Health Care Plan **must** carry with them every day whilst in school their inhaler and a spacer. Can I please point out that for all trips/visits and activity week your child **MUST** have their inhaler with them as unfortunately they will not be allowed on the trip without it.

If your child is discharged from The Asthma Clinic, before they can be removed from the register I must receive a letter from yourself stating that you wish for your child to be removed as they no longer has Asthma.

I look forward to receiving your child’s completed Asthma Health Care Plan.

Thank you for your co-operation in this important matter.

Yours sincerely

Mrs D Brownsword

Student Welfare Officer

**Asthma Health Care Plan**

|  |  |
| --- | --- |
| Child’s Name |  |
| Date of Birth |  |
| Group/Class/Form  |  |
| Child’s Address  |  |
| Date Asthma diagnosed |  |

**Family contact information**

|  |  |
| --- | --- |
| Parent/Guardian Name  |  |
| Phone Number (mobile) |  |
| (home) |  |
| (work) |  |
| Name  |  |
| (mobile) |  |
| (home) |  |
| (work) |  |

**G.P details**

|  |  |
| --- | --- |
| Name & address |  |
| Phone number |  |

**Clinic/Hospital details**

|  |  |
| --- | --- |
| Name & address |  |
| Phone number |  |

Describe how the Asthma affects your child including their typical symptoms and Asthma ‘triggers.’

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| --- |
|  |

Describe their daily care requirements including the name of their Asthma medicine(s), how often is it used and the dose. (e.g once or twice a day, just when they have Asthma symptoms, before sport)

|  |
| --- |
|  |

Describe what an Asthma attack looks like for your child and the action to be taken if this occurs.

|  |
| --- |
|  |

Who is to be contacted in an emergency? Give three contact telephone numbers

|  |  |
| --- | --- |
| Name  | Contact number  |
|  |  |
|  |  |
|  |  |

Form copied to: (to be completed by the school Asthma lead)

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| --- |
|  |

**ADVICE FOR PARENTS/CARERS**

Remember:

1. It is your responsibility to tell the school about any changes in your child’s Asthma and/or their Asthma medication.
2. It is your responsibility to ensure that your child has their ‘reliving’ medication and individual spacer with them in school and that it is clearly labelled with their name.
3. It is you responsibility to ensure that your child’s Asthma medication is up to date.

**The school will not give your child medicine unless you complete and sign this form.**

|  |  |
| --- | --- |
| Name of child |  |
| Date of birth  |  |
| Group/Class/Form  |  |
| Medical condition or illness |  |
| Name and phone number of GP  |  |
| Name/type of medication (as described on the container)  |  |
| Dosage and method |  |
| Are there any side effects that the school needs to know about? |  |
| Procedures to take in an emergency |  |

**Contact details**

|  |  |
| --- | --- |
| Name  |  |
| Daytime telephone number  |  |
| Relationship to child  |  |
| Address  |  |