## ST ANDREW'S CE (VA) JUNIOR SCHOOL PUPIL/ STAFF ASTHMA CARE PLAN

Name:	Date of birth:
Emergency contact:	
Emergency contact number:	
Doctor's phone number:	
What are the signs that you/ your child may be having an asthma attack?	
What are the signs that your your office may be having to	an astima attaox:
Are there any key words that you/ your child may use to express their asthma symptoms?	
What is the name of your/ your child's reliever medicine	e?
What dosage should be given?	
Do you/ your child need help in taking their inhaler? (p	olease circle) Yes No
What are your/ your child's known asthma triggers?	
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Do you/ your child need to take their reliever medicine before exercise? (please circle) <b>No</b> Yes	
If YES, Warm up properly and take 2 puffs (1 at a time) of the reliever inhaler 15 minutes before any exercise unless otherwise indicated below:	
I will ensure that I/ my child has a working, in-date inhaler clearly labelled with my/their name that will be left at school.	
I give my consent for school staff to administer/ assist me/ my child with my/ their own reliever inhaler as required.	
In the event of me/ my child displaying symptoms of asthma, and if my/ their inhaler is not available or is unusable, I consent for me/ my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.	
Signed	oate
Print NameR	delationship to child