Langley First School

September. 2020

Dear Parent\Carer

**School Asthma Care Plan**

We are committed to providing quality care for children with asthma. You will be pleased to know that this school takes its responsibilities to pupils with asthma seriously and that the school has a Medicine in School Policy to enable all staff members to help your child manage their condition.

To ensure your child receives the best possible care at all times, we ask you to assist with the following:-

* Complete the school asthma care plan (if you are in any doubt about the treatment, please take the form to your doctor or asthma nurse for completion)
* Sign the declaration form
* Inform school immediately of any change of treatment (when appropriate)
* Ensure your child has a reliever (blue) inhaler for use in school (and a spacer if this is the usual method of delivery) as well as a home inhaler. School inhaler to be kept in school please during term time.

Please complete even if your child has no symptoms at present and only has a history of asthma. We still need this information. Thank you for your co-operation in this important matter.

Yours sincerely,

Mr T Jones

Headteacher

# **ASTHMA DECLARATION**

I ...........................................(parent/carer’s name) confirm that my child..................................is :-

***a***  *Able to take responsibility for the administration of their own reliever in school (blue) inhaler*

 *when required*

***or***

***b*** *Unable to take responsibility for the administration of their own reliever inhaler (blue) and will require assistance from parent\carer during school hours*

Signed …………………………………….. (Parent\ carer) Date……………………………

**Asthma Care Plan**

Child’s name ……………………………………… Date of Birth…………………………….

Address…………………………………………………………………………………………...................

………………………………………………………………………………………………….....................

Telephone Number ………………………………… Mobile ………………………………….

Emergency contact number……………………………………………………………………................

GP Name ………………………………………….. Telephone No…………………………

**Regular treatment to be given during school hours**

|  |  |  |
| --- | --- | --- |
| Name of medication | Dosage | When to be taken |
|  |  |  |

**Reliever medication to be given as required**

|  |  |  |
| --- | --- | --- |
| Name of medication | Dosage | When to be taken |
|  |  |  |

**Treatment to be taken before exercise**

|  |  |  |
| --- | --- | --- |
| Name of medication | Dosage | When to be taken |
|  |  |  |

**Asthma Triggers (if known)**

|  |
| --- |
|  |

**\*Copy to School ………………………….. (date) \* To be sent by school**