Llangrove CE Academy
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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 an Asthma 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. If you have any questions or wish to see a copy of the Asthma Policy and Procedures, please contact myself. Thank you for your co-operation in this important matter.

Yours sincerely

Mrs Dean
Deputy Head Teacher

Llangrove C E Academy - 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

Parents/carers are asked to update us immediately if there are any changes during the year.

Please complete all information:

Name of Child:	
Date of Birth:	
Address:	
Name of parent/Carer:	
Relationship to child:	
Emergency contact number:	
Telephone Number:	
Mobile Phone Number:	
GP Name:	
GP Telephone Number:	

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)/any other information

Parent/Carer signature:

Signed:	
Printed Name:	
Date:	