ASTHMA STATEMENT

FULWELL INFANT SCHOOL ACADEMY

This statement is for the control and administration of *PRESCRIBED ASTHMA TREATMENT in school*

Name of Child: …… Date of Birth: …….. Class/Year Group: ……..

Address: ……

Asthma Statement:

- This statement should only be completed where a RELIEVER inhaler is required in school (aerosol inhalers, normally blue in colour).
- The school will encourage children with asthma to participate fully in school life.

We ask parents to agree that:

- It is the child's responsibility to request the use of the inhaler, children should be encouraged to administer the treatment independently but school staff will be able to support where needed.
- It is the parents' responsibility to ensure the inhaler is clearly marked with the child's name and with pharmacy label
- It is the parents' responsibility to keep the inhaler up to date and clean.

Name of Treatment ……

Dosage ……

Is this a dry powder inhaler? YES NO (*delete as necessary*)

Dry power inhalers come in the format of Diskhaler, Turbohaler, Easyhaler or Accuhaler – such inhalers do NOT require a spacer device but are normally prescribed WITH an aerosol inhaler.

Is this an aerosol inhaler? YES NO (*delete as necessary*)

Aerosol inhalers are most commonly categorised as Salbutamol (Ventolin) or Terbutaline (Bricanyl) and DO require the use of a spacer device.

NB : ALL aerosol inhalers retained in school for pupil use MUST be provided with the spacer device.

Does your child take any other supplementary asthma treatment (e.g. preventer tablets/steroids). YES NO *(delete as necessary)*

If YES, please specify the medication and whether it would ever be required in school:

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Is there any other information regarding your child's asthma that would assist us in meeting their needs in school?

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TO BE COMPLETED BY THE PARENT/CARER:

- ✓ I request that my child be given the medication as stated overleaf, which has been prescribed by a registered Medical Practitioner. Where applicable, I will also provide any supporting information from my child's GP of their condition.
- ✓ I confirm that I will supply this medication in the form in which is was supplied to me by the pharmacist. I understand the school will NOT accept any medications in unmarked packages and which do not contain the administration details as supplied by the pharmacist.
- ✓ I understand that the medication prescribed should be delivered by me personally to Mrs Boucher/Mrs Gibson in the School Office in the first instance and that this service is subject to agreement with the school. I will make arrangements to collect any unused medicine at the end of the school year.

Contact Information in the Event of Emergency:

1st CONTACT	*2nd CONTACT*
NAME ……..	**NAME ……**
ADDRESS ……	**ADDRESS ……**
DAYTIME TEL NO ……..	**DAYTIME TEL NO ……..**
Mobile No ……..	**Mobile No ……..**
RELATIONSHIP TO CHILD ……..	**RELATIONSHIP TO CHILD ……..**

Child's Doctor ……

Surgery Address ……..

Telephone Number ……..

Any other agency involved in pupil care (Clinic/Hospital/Social Worker) ……...

- I authorise the school representatives to administer medication as required and agreed within this medical statement for the control of my child's asthma condition.
- I understand any emergency treatment will be administered by Mrs Boucher/Mrs Gibson as qualified administrators in the first instance if they are available but it may also be administered by other staff trained in Asthma Care, such as Teaching staff, Teaching Assistants or Midday Supervisors.

Signed: ……..

Relationship to child: …….. Date: ……

Signed: …… Mrs J Boucher, Lead First Aider

Signed:…… Mrs A Gibson, Business Manager

Signed: …….. Headteacher