**ASTHMA INHALER DETAILS**

**Section 1: Pupil details**

|  |  |  |  |
| --- | --- | --- | --- |
| Forename |  | Surname |  |
| Date of Birth |  | | |
| Address |  | | |

**MEDICATION**

|  |  |
| --- | --- |
| Name of Inhaler |  |
| Prescribing GP |  |
| Is your child able to use the inhaler themselves? | Yes / No |
| ***NB.*** *If your child is able to use their inhaler independently they will be encouraged to carry it with them when out of school on trips etc.* | |
| If supervision / help is needed please give details |  |
| Permitted frequency of dosage |  |
| Any side effects of over use of the inhaler |  |
| Procedures to be taken in an emergency |  |

**CONTACT DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Daytime telephone number |  |

I understand that I must deliver the medicine personally to my child’s teacher/admin team and accept that this is a service that the school is not obliged to undertake.

|  |  |
| --- | --- |
| Signature: | Date: |