CARDINAL NEWMAN CATHOLIC PRIMARY SCHOOL

PUPIL ASTHMA FORM

Dear Parents

Please could you complete this form to enable us to make sure that all children with asthma are cared for efficiently and safely whist at School. We would also welcome any suggestions or comments you may have. Thank you for your help.

CHILD'S NAME_____

1. Has your child been medically diagnosed as having asthma? YES/NO

2. If YES G.P.'s name
   _____

   Address _____

   _____ Tel: No _____

3. Does your child take <u>regular</u> daily medication for his/her asthma? YES/NO

4. a) If "YES" please specify
   Name of Medication _____

   Details _____

   b) If "NO" when does your child usually need medication?
   Name of Medication _____

   Details _____

5. Can your child recognise when he/she is in need of medication? YES/NO

6. Does he/she use a particular phrase to indicate the onset of an attack? e.g. "tummy ache", chest pain" etc. YES/NO

   If "YES" please specify_____

7. Can your child administer his/her medication without supervision? YES/NO
   If "NO" what help is required? *Please specify.*

   _____

If your child requires medication for his/her asthma, can you please supply us with spare medication for your child (and spacer if needed) which can be kept at School. Please ensure that any medication is clearly marked with your child's name.

Signed _____ Parent/Guardian Dated _____