

**School Asthma Health Plan**

Date Completed ­­­­­

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| Child’s Name |
| DOB |
| Address |
| Class |
| Parent / Guardians name (1st contact) | (2nd contact) |
| Telephone: | Home: |  |
| Work: |  |
| Mobile: |  |
| GP | Name: |
| Surgery: |
| Telephone: |

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| Does you child tell you when he needs their inhaler? Yes/NoNot always |
| Does your child need help taking their inhaler? Yes/No |
| Does your child need to take their inhaler before physical activity? Yes/No**If only required during a common cold please circle:** With colds only |
| **Medication:** | **Strength** | **Dose** | **When to be taken** |
|  |  |  | **Before activity:****May need before, during and/or after. Staff to observe.**Aim to get through activity without symptomsif possible. |

## My child’s asthma triggers: *(please tick the appropriate boxes of your child’s triggers)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Cold air |  | Colds / viral infections |  | Pollen |  | Stress/anxiety |  |
| Changes in weather |  | Exercise |  | Dust |  | Emotion/ Excitement |  |
| Damp / mould |  | Night |  | Pets |  | Cigarette smoke |  |
| Other: Observe for any unknown triggers |
| **Medication** | **Strength** | **Dose** | **When to be taken** |
|  |  |  | **4 hourly as and when required** |
| **Expiry date Sign by parent/Guardian** |

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| Parent / Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_:Health Professional: GP/Consultant/Practice Nurse/Asthma Nurse/Other:Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

It is recognised that reliever inhalers are prescribed for use by an individual child only and as such they should not be used by anyone else. However, if your child is having a severe asthma attack and his/her reliever inhaler is not readily accessible then there may be circumstances where it is appropriate to use another child's inhaler to relieve the symptoms. This would only occur in exceptional circumstances and your child would be expected to use his/her own inhaler at all other times.

If your child is having a severe asthma attack, and his/her reliever inhalers are not immediately or readily available do you agree your child may use another child’s reliever inhaler? **Yes/No**

Would you give permission for your child’s inhaler to be used by another child who is having a severe asthma attack? **Yes/No**

Is your child known to be allergic to or unable to use any known alternative reliever inhalers? **Yes/No**

(If you are unsure how to answer this question please discuss it with your GP.)

**If yes please provide full details:**

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**This would only happen in an emergency situation**

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| Parent / Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_: |