Singleton Church of England Primary School

Asthma Care Plan

Name

Date of Birth

Date Plan completed

Review Date

Identification of Pupil requiring Asthma Care Plan

Parents identify children that have Asthma on the annual / new to school medical data collection forms

On return of the medical data collection form to school children with Asthma needs are identified. School makes a register and photo medical cards for each classroom

School then follows this up with parents – requesting inhalers be in school at all times

Parents are sent copies of the Asthma care plan and asked to fill in all the details for their child and sign consent forms for self-administration and in an emergency administration by staff of medication

Copy of Care Plan to School, School Nurse and Parents

SHE committee check annually that Care Plans are in place

Care plans and school Asthma register reviewed annually

Asthma Health Care Plan

DATE:-

Child's name	
Class	
Date of birth	
Child's Address	
Date Asthma diagnosed	

Family Contact Information (x3 in case of emergency)

Parent/Guardians Name(Relationship)	
Phone no. Home	
Work	
Mobile	
Parent/Guardians Name(Relationship)	
Phone no. Home	
Work	
Mobile	
Parent/Guardians Name(Relationship)	
Phone no. Home	
Work	
Mobile	

G.P

Name	
Phone No.	

Clinic/Hospital Contact

Name	
Phone No.	

Describe how the asthma affects your child including their typical symptoms and asthma 'triggers'

Describe their daily care requirements including the name of their asthma medicine(s), how often it is used and the dose. (E.g. once or twice daily, just when they have asthma symptoms, before sport)

Describe what an asthma attack looks like for your child and the action to be taken if this occurs

Advice for Parents/Guardians Remember:

- It is your responsibility to tell the school about any changes in your child's asthma and/or their asthma medication.
- It is your responsibility to ensure that your child has their 'relieving' medication and a 'spacer' with them in school **at all times** and that **it is clearly labelled with their name/class.**
- It is your responsibility to ensure that your child's asthma medication has not expired.

I can confirm that I give consent for:-

- For information, I give to school to be shared with appropriate members of staff and outside agencies. (e.g. PE Coaches, School Cook)
- For a my child's photo and medical needs protocols to appear on a medical alert poster – which will be displayed in areas such as near the teachers desk, in the school office and in the school kitchen so that all

adults (including those from external agencies) are aware and can respond to my child's needs effectively

- In the event of a severe asthma I am happy for my child to receive up to 10-20 puffs of their reliever (usually Salbutamol) inhaler via a spacer until they get further medical help.
- I consent that I am happy that the above information be passed onto emergency care staff in the event of an emergency during school hours or during after school activities.

Parent/Guardian Signature……

Date……..

Name of Parent/Guardian

(printed)……

Parental Agreement for School to Administer Medicine in an emergency

The setting will not give your child medicine unless you complete and sign this form, and the setting has a policy that staff can administer medicine

Child's name	
Class	
Date of birth	
Medical condition/illness	
Name & phone number of GP	
Name/type of medicine (as described on the container)	
Dosage & method	
Are there any side effects that the school should know about?	
Procedures to take in an emergency	

Contact Details

Name		
Daytime telephone no.		
Relationship to child		
Address		

I accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school of any changes to my child's medication in writing. The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the setting staff administering medicine in accordance with the setting policy. I will inform the setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Date_____ Signature_____

Please note: It is your responsibility to ensure that the school is kept informed about any changes to your child's medicines, including how much they take and when. It is also your responsibility to provide the school with medication that is clearly labelled and in date

Request for a Child to carry / self-administer their own Medication (inhaler)

(Parents/Guardians to complete this form)

If staff have any concerns about any of the information required for this form they should discuss this with the school nurse

Date sent……

Child's name	
Class	
Address	
Name of medicine (as described on the container)	
Procedures to take in an emergency	

Contact Details

Name		
Daytime telephone no.		
Relationship to child		
Address		

I would like my son/daughter to keep / administer their medication themselves for use as necessary. I understand that I must notify the school of any changes to my child's medication in writing.

Signed _____ _____

Print name _____Date _____

Asthma Consent Form

If your child has been diagnosed as asthmatic and has been prescribed reliever therapy (Blue inhaler) please complete the first part of this form which gives your consent for school staff to give this if required.

I hereby give my consent for school staff to give my child reliever therapy for the treatment of an asthma attack or prior to PE if required. I understand that I will be informed when treatment has been given other than for routine treatment by my request.

Name of child : …… Date-of-birth :

Signed : Parent/Guardian _____Date_____

If your child has asthma you will be sent a copy of the school care plan. Please ensure that your child has a SPARE reliever inhaler and spacer kept in school and that your child's inhaler is within its expiry date.

If your child experiences breathing problems, especially at night or after exercise, or when laughing or crying, or he/she suffers from repeated chest infections please contact your School Nurse.

Request for a Child to carry / self-administer their own Medication (inhaler)

(Parents/Guardians to complete this form – as a prompt for their child / staff if required)

I feel GOOD (Green)

- Breathing is easy.
- No cough or wheeze.
- Can work and play

☐ Use asthma long-term control medicine.

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

Peak Flow Numbers: ____ to ____

20 minutes before exercise or sports, take _____ puffs of _____

I do NOT feel good (Yellow)

- Cough
- Wheeze
- Hard to breathe
- Wake up at night.
- Can do some, but not all activities.

TAKE_____ puffs of quick-relief medicine. If not back in the Green Zone within 20 to 30 minutes, take _____more puffs.

Medicine:	How taken:	How much:	When:
_____	_____	_____	every_____ hours

KEEP USING long-term control medicine:

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

Peak Flow Numbers: ____ to ____

Call healthcare provider if quick-relief medicine does not work OR if these symptoms happen more than twice a week.

I feel AWFUL (RED)

- Medicine does not help.
- Breathing is hard and fast.
- Can't walk well.
- Can't talk.
- Feel very scared

Get help now! Take these quick-relief medicines until you get emergency care.

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Peak Flow Number: Under ____

Call 911 if can't walk or talk because it is too hard to breathe OR if lethargic OR if skin is sucked in around neck and ribs during breaths OR if lips or fingernails are gray or blue.

January 2010