Langley Park
Primary Academy

Asthma Form

Child's Name: _____ Date of Birth: _____

Does the child named above suffer with asthma: **YES / NO**

If your answer is YES please answer all the following questions and sign below:

Name of Medication: _____

Dosage to be given: _____

When: _____

Which of these statements describes the treatment? (tick box)

Relief treatment taken when the symptoms of asthma appear	
Precautionary treatment taken regularly so that attacks no longer occur or are only mild	

Is there any other information regarding your child's health we need to be aware of?

_____

I give permission for the medication prescribed for my child to be administered by the school staff in accordance with the above instructions.

Signed:_____Date_____

Parent/Guardian

To be completed by member of staff at time of giving pump.

Today's Date	Time give	Dosage	Initials of Staff Member