ST. MARY'S C of E PRIMARY SCHOOL

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ASTHMA MEDICAL CARE PLAN

Child's Name…… Class: ……..……

Home address:
……..……

……..……

Emergency Contact & Telephone Number: ……..

Name/ Telephone Number of Family Doctor:
……

……..……..

Inhaler Name: ……

Type of Equipment: ……..

Expiry Date of Medication: ……

I authorise the above prescribed treatment to be administered to my child at:

Time and frequency: ……

Signed…… Parent/ Guardian Date ……

<u>All inhalers and equipment must be labelled and dosage clearly indicated</u>