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# ASTHMA MEDICINE PERMISSION FORM

**for prescribed asthma medication only -**

To be completed by the Parent/Guardian

Child's Name _____Class: _____

Description of Asthma _____

_____

Name of Asthma Medication _____Expiry date _____

Type of pump/medication to be kept at school _____

Symptoms_____

Preventions_____

Frequency use of pump_____ Can child take independently? Yes / No

Name of Parent/s _____

Parents telephone number 1._____ 2._____

GP Name _____ GP telephone number _____

Pump brought in by _____Relationship to pupil _____

**DECLARATION**

I request that the above medication be given in accordance with the above information by a responsible member of the school staff who has received any necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

**I undertake to supply the school with medicines in properly labelled containers that have the label from the chemist with the child's name clearly stated along with the dosage.**

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent, and that the school staff may therefore need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

Parent/Carer Signature _____ Date _____

Staff Signature _____ Date _____

To be reviewed on _____