# Asthma Individual Healthcare Plan

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of school/setting |  | | | |
| Child’s name |  | | | |
| Class |  | | | |
| Date of birth |  |  |  |  |
| Child’s address |  | | | |
| Medical diagnosis |  | | | |
| Date |  |  |  |  |
| Review date |  |  |  |  |
| Family Contact Information |  | | | |
| Name & Relationship to child |  | | | |
| Phone no. (work) |  | | | |
| (home) |  | | | |
| (mobile) |  | | | |
| Name & Relationship to child |  | | | |
| Phone no.(work) |  | | | |
| (home) |  | | | |
| (mobile) |  | | | |
|  |  | | | |
| Clinic/Hospital Contact |  | | | |
| Name |  | | | |
| Phone no. |  | | | |
| G.P. |  | | | |
| Name |  | | | |
| Phone no. |  | | | |
| Personal Asthma plan shared from GP/Nurse | Copy given to school on : | | | |

|  |  |
| --- | --- |
| Who is responsible for providing support in  school | All staff |

Describe asthma medical needs and give details of child’s symptoms/signs and triggers

|  |
| --- |
| Triggers –  Symptoms – |

Name of medication, dose, method of administration, when to be taken, side effects, administered by/self-administered with/without supervision

|  |
| --- |
| Medication –  Dose –  How it is administered- |

Arrangements for school visits/trips etc

|  |
| --- |
| Class Teacher/staff will hold the medication. |

Other information

|  |
| --- |
|  |

Describe what constitutes an emergency, and the action to take if this occurs

|  |
| --- |
|  |

I give consent for school to use Salbutamol in an emergency if my child’s inhaler is not in school.

Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan developed with Parents/Carers

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_