Toll Bar Primary School

Asthma Form

Child's name:		**Class:**	
Date of birth:			
Home address:			
Parent's/Guardian's name:			
Telephone:	Home:		
	Work:		
	Mobile:		
General Practitioner:	Practice:		
	Telephone:		
Name of reliever medication:			
Dose required and when:			
Does your child need help taking asthma medication?	Yes/No	Does your child need to use a spacer device when taking medication?	Yes/No
Does your child need to take their medication before exercise or play?	Yes/No	If Yes, please state when and dosage required:	
What (if any) are your child's asthma triggers (things that make their asthma worse)?			
Have you supplied 1 inhaler? *(Please ensure that inhalers are within expiry date)*	1 inhaler kept in the classroom at all times Yes/No	Expiry Date	

Signature of parent/guardian .... **Date** ....