



Asthma Health Care Plan

Child's Name:		
DOB:		
Address:		
School:		Class:
Parent / Carer's name:		GP Name:
Telephone -	Home:	Surgery:
	Work:	Surgery's Telephone:
	Mobile:	

Does your child tell somebody when s/he needs their inhaler? Yes / No

Does your child need help taking his/her inhaler? Yes / No

Does your child need to take their inhaler before exercise or play? Yes / No / Occasionally		
Medication:	Dose:	When to be taken:

My child's asthma is triggered by: *(please tick the appropriate boxes)*

Cold air		Colds / viral infections		Pollen		Excitement	
Changes in weather		Exercise		Dust		Emotion	
Damp / mould		Night		Pets		Cigarette smoke	
Other:							