



ASTHMA

Individual Health Care Plan

to be used if no consultant care plan available

PARENTS/CARERS TO COMPLETE FOR SCHOOL

NAME OF STUDENT

DATE OF BIRTH TUTOR GROUP

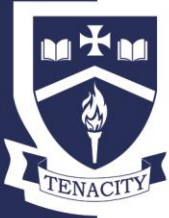
KNOWN TRIGGERS

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CONTACT INFORMATION No 1	CONTACT INFORMATION No 2
NAME	NAME
RELATIONSHIP TO STUDENT	RELATIONSHIP TO STUDENT
HOME TELEPHONE	HOME TELEPHONE
WORK TELEPHONE	WORK TELEPHONE
MOBILE TELEPHONE	MOBILE TELEPHONE

CLINIC/HOSPITAL CONTACT	GP
NAME	NAME
CLINIC/HOSPITAL	PRACTICE
TELEPHONE	TELEPHONE



Health & Safety Risk Assessment

(to be carried out by school)
to review presence of known triggers

Date

Planned review of Risk Assessment

Date

NAMES OF SCHOOL STAFF WHO HAVE VOLUNTEED TO BE INVOLVED IN THIS CHILD'S CARE	
NAME	NAME
NAME	NAME

Outline of procedure/condition requiring management

Describe condition and give details of student's individual symptoms

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Describe treatment required

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LOCATION OF ASTHMA INHALER

**LOCATION OF SPARE INHALER
(AND SPACER IF APPROPRIATE)**

Parent/Carer's signature(s)

Relationship to student Date

- COPIES TO:
- PARENTS
 - SCHOOL HEALTH
 - GP/CONSULTANT

