

# **BEACONSFIELD HIGH SCHOOL - HEALTHCARE PLAN**

## **PUPILS WITH ASTHMA**

**Surname:** .....

**Forenames:** .....

**Date of Birth:** .....



**Trigger(s):** .....

.....

**I consent to a member of staff administering** .....

.....  
(name of medication as described on the container)

**Dosage and method of administration:** .....

.....

**Describe in detail when medication should be administered and any emergency actions (call ambulance, parents etc.):** .....

.....

.....

**IT IS THE PARENT'S RESPONSIBILITY TO ENSURE THAT MEDICATION IS IN DATE.**

### **Emergency Contact 1**

### **Emergency Contact 2**

**Name:** ..... **Name:** .....

**Main Contact No:** ..... **Main Contact No:** .....

**Alternate Contact No:** ..... **Alternate Contact No:** .....

**I consent to the administration of the school's spare Ventolin if my child's medication is not available. (delete as appropriate)**

**Yes/No**

**Signed:** .....

**Date:** .....