



Asthma Form

Child's Name: _____

Date of Birth: _____

Does the child named above suffer with asthma: **YES / NO**

If your answer is YES please answer all the following questions and sign below:

Name of Medication: _____

Dosage to be given: _____

When: _____

Which of these statements describes the treatment? (please tick box)

Relief treatment taken when the symptoms of asthma appear	
Precautionary treatment taken regularly so that attacks no longer occur or are only mild	

Is there any further information regarding your child's health we need to be aware of?

I give permission for the medication prescribed for my child to be administered by the school staff in accordance with the above instructions.

Signed: _____ Date _____
Parent/Guardian

