# FULWELL JUNIOR SCHOOL:

**PARENTAL AGREEMENT FOR THE MANAGEMENT OF ASTHMA TREATMENTS 2020-21:**

* The School will NOT give your child medicine unless you complete and sign this form; the School has a policy in place to confirm that appropriate staff can administer medicine.
* School will only administer medication that has been prescribed by a Medical Practitioner.
* School will NOT accept any medication in unmarked/un-named packages or where dosage details are unclear.

Medication must be handed over by an adult; any medication left at the end of a prescribed course must be collected from school by an adult.

***Asthma Statement:***

* This statement should only be completed where a **RELIEVER** inhaler is required in school (aerosol inhalers, normally blue in colour).
* The school will encourage children with asthma to participate fully in school life.
* We recognise it is essential that children can reach their medication easily; all asthma treatments will be retained by the class teacher in a clearly marked receptacle.

We ask parents to agree that:-

* + It is the child’s responsibility to request the use of the inhaler; children should be encouraged to administer the treatment independently but school staff will be able to support where needed;
  + It is the parents responsibility to ensure the inhaler is clearly marked with the child’s name;
  + It is the parents’ responsibility to keep the inhaler up to date and clean.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Child: |  | | | |
| Date of Birth: |  | | | |
| Class: |  |  |  |  |
| Date Inhaler Issued to School: |  | | | |
| Spacer Device Provided:  **NB : All aerosol inhalers MUST be provided with the spacer, even if your child often takes the medication without it.** |  | | | |
| **Medicine** |  | | | |
| Name/type of Inhaler:  *(as described on the container)* |  | | | |
| Amount provided to school: |  |  |  |  |
| Type: (Dry Powder or Aerosol) |  |  |  |  |
| Expiry Date: |  | | | |
| Maximum dosage within 24 hours: |  | | | |
| Dosage to be given: |  | | | |
| Time to be given: |  | | | |
| Special precautions/other instructions |  | | | |
| Are there any side effects that the school needs to know about? |  | | | |
| Self-administration – Y/N |  | | | |
| Procedures to take in an emergency |  | | | |
| **NB: Medicines must be in the original container as dispensed by the pharmacy**  **Contact Details** | | | | |
| Name of adult providing medication: |  | | | |
| Daytime telephone no. |  | | | |
| Relationship to child |  | | | |
| Address |  | | | |
| I understand that I must deliver the medicine personally to one of the schools first aiders and I have given this medication to: | **Registered First Aiders: *(Delete as appropriate)***  Miss Cook  Mrs Skinner  **Other:**  *Received in reception by Office Management:*  *Mrs Anderson*  *Miss Donoghue* | | | |

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) Date