# Asthma Register

If you child suffers from Asthma, please complete this form and return to the school office as soon as possible. **A separate form for each child is required.**

**Child's name:**_____ **Class:**_____

My child has asthma. He/she needs to take medication if any of these symptoms (Eg. wheezing, chest tightness, shortness of breath, coughing) occur:

1. _____
2. _____
3. _____

**Is your child's asthma:**

Seasonal – affected only in a specific season like autumn or spring YES NO

Constant – all year round YES NO

Constant and seasonal – all year round but worse in some seasons YES NO

If yes , which seasons_____

Caused by exercise YES NO

Does your child use a puffer or require medication? YES NO

**If yes:**

Type of medication_____Dosage_____

How often_____Equipment: Puffer/Spacer/Nebuliser

If my child's symptoms persist I give permission to use the nebuliser. YES NO

**If yes:**

☐ I have forwarded my child's medicine and puffer/spacer/mask **WITH NAME AND DOSAGE CLEARLY MARKED** to the school.

☐ I have supplied my child's current asthma plan from my general practitioner.

Signed_____ Date_____

Contact Name and number:_____